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VOLUME LII JUNE, 1956 NUMBER 6

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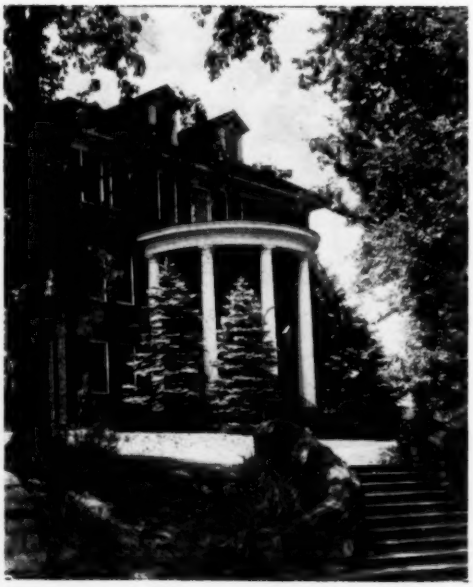

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The Journal
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VOLUME LII June, 1956 NUMBER 6

AN ANALYSIS OF THE MEMBERSHIP OF THE SOUTH CAROLINA MEDICAL ASSOCIATION*

O. B. MAYER, M. D.
Columbia, S. C.

The President's address has, traditionally, been a philosophical and ethical dissertation to stimulate and inspire. This year I would like to present a different line of thought, namely: to offer a survey of our Association, or, in effect, take stock of our membership. The Association is no stronger than its members, and its service to the people of this State is no better than the talents and training of individual physicians. This State is advancing and progressing in many ways, some of which are startling. This Association must grow and meet the medical requirements of an increasing population and a diversified economy. The Association must have vision and concept of this medical need and be able to offer it, else the ever-present proponents of socialized and state medicine rush in with plans that would smother the present ideal doctor-patient relationship.

This presentation itself will not answer the questions, but it could be a basis for further evaluation and help in our future guidance.

According to the History of the South Carolina Medical Association, edited by Dr. J. I. Waring, the first graduating class of the Medical College of South Carolina was in 1825. By the end of the first twenty-five years of the school, or approximately 100 years ago, 1273 medical students had graduated, which is about fifty a year. Others had received their diplomas from medical schools out of the State, and many continued to get their training solely by practicing two or three years with a licensed physician and then passing the State Board of Medical Examiners. At that time it was relatively easy to become a doctor, which, in part, may account for the large number and inadequately trained doctors of the earlier period. About 1887 the Medical Practice Act was altered to require a medical diploma before becoming eligible for Board Examination.

By 1900 the requirements for entrance into the Medical College had risen and medical training vastly improved, with a reduction of approximately 50% in the number of practicing physicians, although the State's population had risen to 1,340,316.

The population of South Carolina was 668,507 in 1850, and in 1852 the estimated number of doctors was between 900 and 1000, or about one doctor to every 650 persons. Some fifty years later, namely, 1906, the doctor population had shrunk to 587, and the State's population had grown to 1,340,316, with one doctor to every 2280 persons.

In presenting statistics of doctors and population, it is realized that figures are subject to variabilities beyond control. The figures have been checked as closely as possible with available 1955 data. It is believed that they are quite representative of existing conditions. The current figures about the South Carolina doctors were obtained through the Executive Secretary's office in Florence and through courtesy of the State Board of Health.

*Presidential address, given at Myrtle Beach, May 17, 1956.

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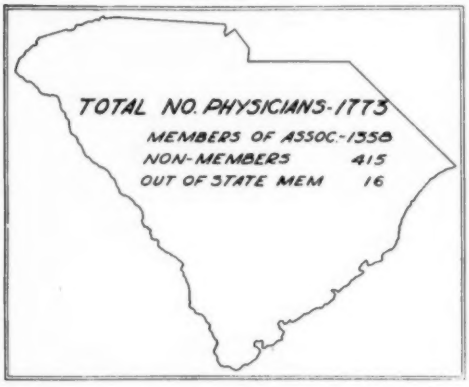
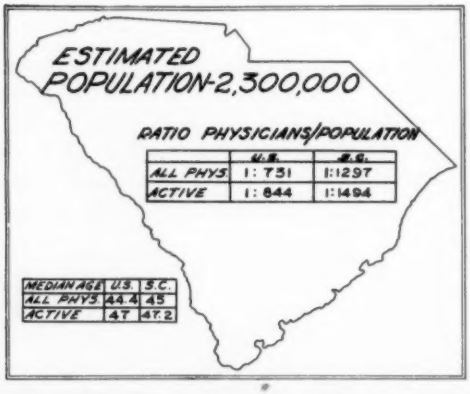
The 1955 statistics show a total of 1773 doctors in the State. (table 1) The Association

TABLE 1



has 1358 members in good standing. Of these, 134 are classified as Honorary (members in good standing who have practiced for forty consecutive years in the State), 55 Retired (presumably practice little), 29 in Military Service, and 16 are temporarily out of the State. These comprise a group of 234, leaving 1539 physicians in the State, in full time active practice, for the State's currently estimated population of 2,300,000, or a ratio of one doctor to every 1494 persons, or using the all doctor number—1773, the ratio is 1:1297. (table 2)

TABLE 2



By referring to AMA Bulletin No. 94, 1954, the following is noted: The 1950 ratio of all physicians in the United States is one to 731 persons, and of actively practicing physicians one to 844 persons. The median age of all doctors in the United States is 44.4 years, and of doctors in active practice 47 years. The corresponding figures for South Carolina are: all—45 years, and active—47.2 years. (table 2)

The doctors of the State comprise a group composed of general practitioners and many specialists. Where are the various kinds of doctors located? What is the number of general practitioners, and the kind and number of specialists? (table 3, 4, 5)

TABLE 5

Medical Administration	9
Anesthetists	16
Derm. & Syph.	14
Industrial Medicine	13
Internal Medicine	110
EENT	72
Orthopedists	28
Ob.-Gyn.	61
Pathologists	15
Pediatricians	69
Proctologists	4
Psychiatrists	31
Public Health	27
Radiologists	28
Surgeons	176
TBc	7
Urologists	33
Residents & Interns (70) (104)	174
General Practitioners	780
Unknown	106
Total	1773

The general practitioners of the United States comprise a group of 37.2%, and for South Carolina 45%. Full time specialists in the United States account for 27.8%, and in South Carolina 21.1%. Part-time specialists in South Carolina represent 11.7%. The remaining group of 22.2% is a miscellaneous group. An interesting group is the 44 women doctors. (table 6)

We shall now show where the physicians are located, and the doctor-population ratio in the 9 Medical Districts, with an estimated 1955 population.

TABLE 3

DISTRIBUTION OF PHYSICIANS IN SOUTH CAROLINA

County	Total M.D.s in	Non Association Members				Medical Association Members						
		W	N	Unk.	Total	W	N	Out of S. C.	Total	Honorary	Ret.	In Service
Abbeville	12	4	0	0	4	8	0	1	9	1	0	0
Aiken	38	11	0	1	12	26	0	0	26	3	3	0
Allendale	5	1	0	0	1	4	0	0	4	1	0	0
Anderson	81	4	1	0	5	74	2	0	76	10	4	2
Bamberg	13	1	0	1	2	11	0	0	11	0	0	0
Barnwell	13	2	1	0	3	10	0	0	10	0	0	0
Beaufort	14	2	2	0	4	10	0	0	10	1	2	0
Berkeley	10	2	1	0	3	7	0	0	7	1	0	0
Calhoun	6	0	0	0	0	6	0	0	6	2	0	0
Charleston	281	96	2	0	98	178	5	4	187	20	8	8
Cherokee	12	1	0	0	1	10	1	0	11	1	0	0
Chester	18	3	0	0	3	14	1	1	16	3	1	2
Chesterfield	13	1	0	0	1	12	0	0	12	2	0	1
Clarendon	7	0	0	0	0	7	0	0	7	3	2	0
Colleton	19	7	0	0	7	12	0	0	12	2	0	0
Darlington	24	7	1	0	8	16	0	0	16	4	1	0
Dillon	14	4	1	0	5	9	0	0	9	0	1	0
Dorchester	10	3	0	0	3	7	0	0	7	0	0	1
Edgefield	10	2	0	0	2	8	0	0	8	1	0	0
Fairfield	7	2	0	0	2	5	0	0	5	0	0	0
Florence	73	14	7	0	21	52	0	2	54	2	1	1
Georgetown	17	4	2	0	6	11	0	0	11	1	0	0
Greenville	192	30	1	0	31	158	3	2	163	15	7	4
Greenwood	42	2	2	0	4	38	0	0	38	3	1	0
Hampton	11	1	0	0	1	10	0	0	10	0	0	0
Horry	38	12	0	0	12	26	0	0	26	1	0	0
Jasper	4	1	0	0	1	3	0	0	3	0	0	0
Kershaw	26	6	2	0	8	18	0	0	18	1	1	0
Lancaster	12	0	1	0	1	11	0	1	12	0	0	0
Laurens	24	2	1	1	4	20	0	0	20	4	3	0
Lee	7	2	0	0	2	5	0	0	5	0	0	0
Lexington	17	1	0	0	1	16	0	0	16	4	2	0
McCormick	1	0	0	0	0	1	0	0	1	0	0	0
Marion	26	3	2	1	6	20	0	0	20	2	1	1
Marlboro	16	3	0	0	3	13	0	0	13	1	0	1
Newberry	22	2	0	0	2	20	0	1	21	2	1	1
Oconee	22	2	1	0	3	18	1	0	19	1	0	0
Orangeburg	43	5	2	0	7	36	0	0	36	4	1	1
Pickens	24	3	0	0	3	21	0	0	21	4	2	0
Richland	296	97	7	2	106	190	0	1	191	18	9	1
Saluda	4	0	0	0	0	4	0	0	4	0	0	0
Spartanburg	138	12	2	1	15	120	3	0	123	7	2	4
Sumter	38	2	3	0	5	33	0	0	33	5	1	1
Williamsburg	17	3	0	0	3	14	0	0	14	2	1	0
Union	12	1	0	0	1	10	1	2	13	2	0	0
York	44	3	2	0	5	39	0	1	40	0	0	0
Total	1773	364	44	7	415	1341	17	16	1374	134	55	29

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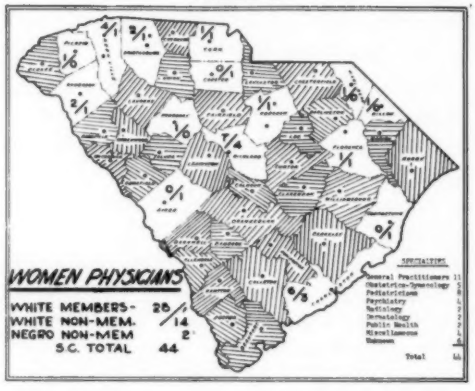
TABLE 4 DISTRIBUTION OF PHYSICIANS IN SOUTH CAROLINA ACCORDING TO TYPE OF PRACTICE

County	Adm.	Anes.	Derm. Syph.	G.P.	Indu.	Int. Med.	EENT	Orth.	Ob. Gyn.	Path.	Ped.	Proc.	Psyc.	Pub. H.	Rad.	Surg.	TBc	Urol.	Ret.	Unk.	Total
Abbeville				7		1								1		1				2	12
Aiken				15	10				2		2			1		2			3	3	38
Allendale				5																	5
Anderson		2		39		3	7	1	5	1	5			1	1	9		3	4		81
Bamberg				9			1							1		1				1	13
Barnwell				10												1		1		1	13
Beaufort				7										1		4			2		14
Berkeley				7										1		1				1	10
Calhoun				6																	6
Charleston	5	10	4	59	2	37	12	9	16	9	20		6	3	7	27	1	7	8	39	281
Cherokee				10												2					12
Chester				13										1		3			1		18
Chesterfield				13																	13
Clarendon				4												1			2		7
Colleton				16										1	1	1					19
Darlington				18		1	2							1		1			1		24
Dillon				10							1					1			1	1	14
Dorchester				10																	10
Edgefield				7					1					1						1	10
Fairfield				5										1		1					7
Florence			1	33		8	6	3	2		3			1	2	6	1	2	1	4	73
Georgetown				12							1				1	2				1	17
Greenville		3	3	76		15	10	4	9	1	11	2	3	1	4	21	1	5	7	16	192
Greenwood				17		3	3	1	4	1	2				1	4		2	1	3	42
Hampton				10												1					11
Horry				21		4	2		1		2			1	3	4					38
Jasper				4																	4
Kershaw				17		2					2					3			1	1	26
Lancaster				10												2					12
Laurens	2			17												1			3	1	24
Lee				5										1		1					7
Lexington				13		1								1					2		17
McCormick				1																	1
Marion				15		1								1		6			1	2	26
Marlboro				11		2										3					16
Newberry				12		2	1				1			1		3			2		22
Oconee				18										1		2				1	22
Orangeburg		2		22		3	2		2		2			1	1	3		2	1	2	43
Pickens				17			1							1		1			2	2	24
Richland	1	2	5	56	1	24	12	9	14	2	11	1	22	10	5	29	4	7	9	72	296
Saluda				4																	4
Spartanburg		2	1	59		11	6	3	8	1	6	1	1	2	3	20		4	2	8	138
Sumter		1		14		2	4		3		2			1	1	8		1	1		38
Williamsburg				12		1	1							1					1	1	17
Union	1			10		1															12
York				24		3	2		2		2				1	8		1		1	44
Total	9	22	14	780	13	125	72	30	69	15	73	4	32	38	31	184	7	35	56	164	1773

TABLE 6



It is believed by some that there are more doctors in the Piedmont than in other parts of the State. The figures appear as follows: The Piedmont area, comprising seventeen counties in the northwest part of the State, has 665 doctors and a population of 931,600, which gives approximately one doctor for every 1400 persons. The remaining part of the State is divided into the Pee Dee and Coastal sections. The Pee Dee has 624 physicians and a population of 789,162, or a physician-population ratio of 1:1265. The Coastal area has 484 physicians and a population of 579,238, or a physician-population of 1:1196.

There is a group of counties with less than ten doctors each, namely: Calhoun 6, McCormick 1, Jasper 4, Saluda 4, Allendale 5, Clarendon 7, Fairfield 7, Lee 7. The Negro population of these counties exceeds or approximates the white. The medical care in these counties is augmented from the surrounding counties. Similar situations exist in other states besides South Carolina.

Looking at the entire picture, South Carolina is below the national average in the number of physicians to population. It is evident that South Carolina's population is increasing rapidly. The officials of the Medical College of South Carolina wisely foresaw this doctor need and the legislature rightly provided the necessary funds to improve and increase the Medical College facilities, so that 80 doctors can now be graduated a year. This number is now considered ample for the State's needs.

Negro doctors comprise a group of 17 members, and 44 non-members, 3 of which are women. The following table shows the first 4 members came from Charleston in 1952, and then the following year one more from Charleston, one from Chester, 3 from Greenville, and 2 from Spartanburg. In 1954 one came from Cherokee, and one from Union. In 1955 2 came from Anderson, 1 from Oconee, and 1 from Spartanburg.

TABLE 7

Medical District No.	Composed of	Population (1955)	No. Doctors (1955)	Ratio
1	Charleston, Colleton, Jasper, Dorchester, Berkeley, Beaufort counties	298,680	338	1:880+
2	Edgefield, Aiken, Lexington, Richland, Saluda	285,995	365	1:783+
3	Laurens, Newberry, Greenwood, Abbeville, McCormick	160,245	101	1:1586+
4	Anderson, Greenville, Oconee, Pickens	354,989	319	1:1112+
5	Chester, Kershaw, Lancaster, York, Fairfield	205,205	107	1:1918
6	Florence, Darlington, Chesterfield, Marlboro, Dillon, Marion, Horry	337,628	204	1:1165
7	Clarendon, Georgetown, Lee, Sumter, Williamsburg	198,082	86	1:2300—
8	Allendale, Bamberg, Barnwell, Calhoun, Hampton, Orangeburg	155,794	91	1:1712
9	Spartanburg, Union, Cherokee	227,682	162	1:1404

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TABLE 8

County	1952	1953	1954	1955	Totals
Anderson				2	2
Charleston	4	1			5
Cherokee			1		1
Chester		1			1
Greenville		3			3
Oconee				1	1
Spartanburg		2		1	3
Union			1		1
Total Negro Members					17

The Negro group of 61 doctors accounts for less than 3.5% of the profession, while the Negro population is about 40%.

The Negroes, as a whole, reside primarily in the sandhills and coastal sections, while most of the Negro doctors are in the Piedmont and industrial sections. There is not a Negro doctor in Clarendon County or in 21 other counties.

There are, on an average, up to 6 Negro doctors that take the State Board of Medical Examination per year, and generally, they all pass. Of those practicing, one is a Board man in ophthalmology practicing in Columbia.

A hundred years ago the profession was made up 100% of general practitioners. As the percentage of general practitioners went down and the percentage of specialists rose, there was a corresponding deterioration in public relations; not that medicine was poorer thereby, but the public lost something that was dear to it.

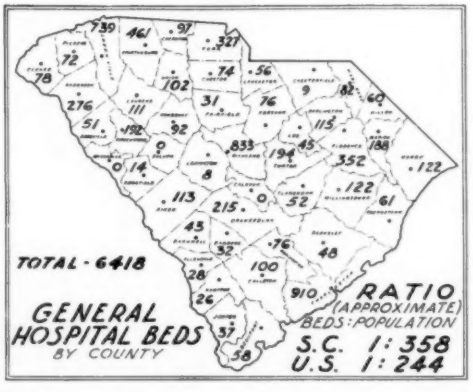
The public relations in South Carolina are better than the national public relations. The percentage of general practitioners in South Carolina is higher than the national percentage. I expect, if the national percentage of general practitioners were higher, the public relations would be smoother.

The distribution of physicians is frequently discussed by various agencies, pointing out the trend of physicians to locate in cities rather than rural areas. This actually is not too serious or too unexpected. The doctor of today is highly trained in treatment and diagnosis, and is dependent upon the laboratory, x-ray, and hospital for proper medical or surgical management of the patient. To locate in a community without modern facilities is to deprive himself and his patient of the scientific aids he has been taught to utilize.

The patient's sickness, on the other hand, is seldom aggravated by going to the doctor's office or hospital, and in instances, the doctor, upon visiting the patient at home, can only recommend transfer to a center for appropriate treatment. As diagnostic centers and hospitals increase in our State, as they rapidly are, the public will become more accustomed and dependent on this modern trend of medical practice. The idea of doctors shunning the rural for community practice will become justified and reconciled.

At the present time there are 6418 general hospital beds in South Carolina, (table 9) exclusive of those for Tuberculosis and Mental and Nervous Diseases, and those on military installations and the Veterans' Administration.

TABLE 9



The hospitals are scattered over the State except that Calhoun, McCormick, and Saluda counties have none. Health Centers and Auxiliary Units are in every county. South Carolina population to general hospital bed is one bed to every 358 persons. The ratio for the United States is 1:244. The doctor in a center, provided with modern technical assistance, can care for many more patients and in a better way than ever before.

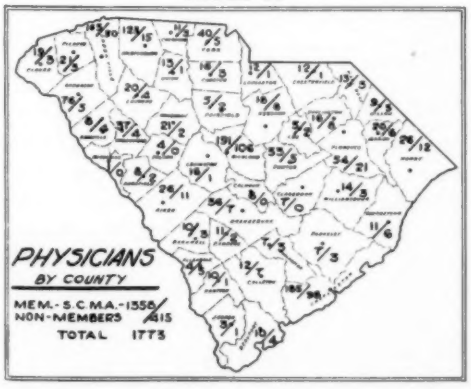
The graduate doctor of today, by clinical experience with patients while a medical student, and later as an intern and resident, has had training in various branches. This leads

me to believe that the physicians starting practice today are prepared, not only to do general practice, but also to provide specialized treatment in certain conditions. Those rarer and complicated conditions requiring highly specialized training and equipment are referred to specialists, thus utilizing the specialist effectively in his field.

This concept of practice places the general practitioner in an enviable position, gives him a broader field, and a more satisfactory relationship with the patient. Families have long desired one doctor who can treat the patient except for unusual conditions. The public's criticism of over-specialization should become less with more and better general practitioners. Instead of every intern and resident feeling he must avail himself of a particular specialty, let us encourage good preparation for general practice. The general practitioner is in a unique position for rendering the most service to the most patients. The profession needs them . . . The people want them . . . The medical schools and hospitals can provide them.

There are approximately 415 doctors in this State who are not members of the South Carolina Medical Association. (table 10) The

TABLE 10



largest group of 120 is found in District No. 2, consisting of Edgefield, Aiken, Lexington, Richland, and Saluda counties. The first question that comes to mind is: Why are they not members? An analysis of available statistics of Richland county shows that the non-member group of 106 consists of 40 doctors in institutional work as the Veterans' Administration, State Hospital, State Park Sanitarium, 25 as interns and residents, 7 Negroes, leaving a group of 21 doctors unclassified except as non-members. Aiken county has 11 white non-members, Edgefield 2, Lexington 1. The next largest group of 116 is in District No. 1. Charleston county accounts for 98 of them, Colleton 7, Jasper 1, Dorchester 3, Berkeley 3, and Beaufort 4. Of this entire group, 5 are Negroes. Other counties showing a surprising number of non-members are: Florence 21, Greenville 30, Horry 12, Kershaw 8, and Spartanburg 15. The general picture of non-members in the cities with large membership is about the same as Richland's non-members. The hospital or institutional group accounts for many of the non-members. In other instances, careless or unsympathetic attitude about dues or, rarely, ineligibility may account for non-membership.

There is another large group of interns and residents. A few years ago the House of Delegates provided a special Junior Membership for them so that they would not be liable for regular dues, but pay only for the subscription price of *The Journal*. As far as I know, very few interns or residents have come into the Association by this route. I urge the component societies whose hospitals have interns and residents not only to provide the necessary change in their by-laws but also invite and urge these doctors to affiliate. I believe they will find affiliation with organized medicine invaluable even during hospital training or military service. A doctor is a better doctor when a member of the Association. However wholehearted a society's invitation may be to non-members, there is apt to be a feeling of hesitancy and less attendance at the scientific meetings.

How can an appeal be made to the non-members, and what ways can be made for them to become members? In instances, the amount of dues may be a deterring factor. County, State, and AMA dues in this state may run from $50.00 to $100.00 or more a year. It is regretable that dues may keep some men out of organized medicine. The dues are tax deductible and are not as much as they

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seem on the surface. No doubt, there are those whose expenses do not encourage this expenditure for membership. In other instances, it may be thoughtlessness on the part of the non-member, or societies may be negligent in not meeting the problem of the individual who wants to carry his part or is shy about seeking membership. I suggest that the county societies make a careful study of this problem. Perhaps a more elastic or graduated scale of dues could be adopted. I suppose that the percentage of non-members in our state is not higher than the national average, but no figures are available. Could a goal be set that every eligible doctor become a member? It is up to each county to survey its doctor population and help each eligible doctor become a member.

Every physician owes a debt to the profession past and present. No doctor today, whether his medical education was financed by the government or by private means, can escape his obligation to organized medicine. Medical history shows how the profession has constantly striven for the highest standards of medical education, urged and helped medical colleges to maintain class "A" standards. Physicians have given freely of their time in teaching students in the classroom and clinic. Actually, the efforts and insight of our predecessors made modern medical education possible. Medical societies are conscious of their responsibility of safeguarding and advancing the practice of medicine and keeping their members posted on the best medical procedures.

In conclusion, I have tried to picture the doctor potential in South Carolina, where our strength is, and where our weakness is. The non-member group of 415 appears too large. Approximately one doctor in 4-1/2 is a non-member. South Carolina has one physician for approximately 1300 persons. The nation, as a whole, has one physician to every 731 persons. The South Carolina physician requirement probably lies between these figures. More doctors are needed in our State. However, no crisis exists, and the physician deficit is becoming less. Our resident-intern pool is substantial. As industry expands, additional needs will develop. The general hospital bed ratio to population is low but constantly improving. The medical care in our State is excellent. Numbers alone do not insure adequate care. Where shortages of physicians occur, we find the local physician extending himself. South Carolina has fewer doctors and older doctors. South Carolina doctors work harder and over a longer span of years than the average in the United States. Physicians are invaluable citizens, and cannot be easily replaced. Better public relations, better patient's-understanding, and better distribution of doctors will help. But it is by graduating sufficient number of doctors that shortages will be overcome. South Carolina has a good proportion of accredited specialists. I believe the shortage of physicians in our state could best be filled by general practitioners. The general practitioners have an unusual opportunity to foster smoother public relations.

Hospitals and health centers are rapidly developing in many areas, making practice in these localities more inviting and enabling the doctor to give better care to the patient.

South Carolina has every reason to be proud of her doctors, who they are, and what they are doing. We look forward with eagerness, believing confidently that new scientific advances will solve many of today's perplexing problems.

May we continue to carry on in the spirit of the motto of the South Carolina Medical Association—with Virtue, Honor, Wisdom, and Humility.

SURGERY FOR CHRONIC ARTERIAL INSUFFICIENCY OF LOWER EXTREMITIES

Wm. H. Moretz, M. D.*
Augusta, Georgia

Along with the continually increasing life expectancy, there is a greater incidence of those degenerative diseases commonly seen in elderly people, including chronic arterial insufficiency of the lower extremities. Fortunately, advances are being made in the surgical treatment of arterial insufficiency which brightens the outlook for those suffering with this difficulty.

Many different ideas and new procedures are being used experimentally and clinically by many workers in this field. The sometimes conflicting reports from the different investigators are at present based on relatively short term results and the conclusions drawn now may have to be altered when the procedures are re-evaluated after long term observation. Although many of the controversial points may not be solved for many years, the main principles have already been so well established that these new procedures warrant careful consideration in the management of those with chronic arterial insufficiency. It is hoped that this report will emphasize that much can now be done for those with chronic arterial insufficiency, even though many of the procedures are new and many of the problems are still unsolved.

Pathology—

The cause of chronic arterial insufficiency in the elderly is usually arteriosclerosis, which occurs earlier and more commonly in diabetics than non-diabetics. Thrombo-angiitis obliterans (Buerger's disease) and the LeRiche syndrome[1] are more frequently responsible in younger males. LeRiche Syndrome (easy fatigue of lower limbs, impotency and absent femoral pulsations) is characterized by segmental occlusion of the terminal aorta usually involving the iliac arteries. More peripherally, segmental occlusions are seen, not uncommonly in the earlier stages of arteriosclerosis, although in the late stages the arterial changes are usually extensive and diffuse. Only by making arteriograms fairly routinely in such patients can those with segmental occlusions be found and selected for direct vessel surgery. In those with segmental occlusions, although it is to be expected that the less involved portions of arteries will become more diseased and perhaps even become occluded, great benefit results from restoring surgically the blood flow through or around the segmentally occluded area.

Indications for Elective Surgery—

Certainly not all patients with diminished arterial blood supply to their lower extremities require or warrant operative treatment. Most are quite elderly and relatively asymptomatic and are likely to die of some other degenerative or malignant disease before getting into serious difficulty with the lower extremities. Probably of greater overall importance than any specific type of surgery in the treatment of these patients is the institution of good general hygiene and proper local foot care. These measures may prevent the minor infections and abrasions which so often convert a mildly ischemic, and even asymptomatic limb into an immediate threat to life. This is especially true in patients with diabetes.

In deciding on the advisability of surgery for any particular patient, one must consider not only the type of pathological change present but also whether or not any presently available procedure is effective in treating that type of disease. A 60 year old male may have very severe arteriosclerosis, diffusely involving an extremity and producing ischemic neuritis and "rest pains". There is no doubt that such an

*Chairman, Department of Surgery, Medical College of Georgia, Augusta, Georgia.

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individual sorely needs something to improve the flow of blood in his extremity, but experience has shown that no surgical procedure will produce enough benefit to prevent the need of amputation. In such an instance then, the logical treatment is primary amputation rather than one of the procedures to improve the blood supply. Or, a 50 year old person with few symptoms may have a segmental occlusion which can be by-passed with the prospect of getting very good results. Surgery is probably advisable for such an individual, even though the symptoms may be minor, because it is highly successful for the type of disease present.

Generalizations are dangerous and the decision as to whether surgery may be indicated can be made best after considering all the pros and cons in each individual patient. However, most authorities would agree that surgery should be seriously considered for those with arterial insufficiency severe enough to produce symptoms, in whom operation is not contraindicated because of coexistent disease or extreme old age, and in whom the type of pathological change present is such that some form of surgical procedure would be likely to cause improvement.

Operative Measures to be Considered—

Those procedures aimed at improving the blood supply and saving the extremity (with which this report is primarily concerned) may be considered in two general categories: (1) The direct vascular approach and (2) The approach through the sympathetic nervous system. The direct vascular approach consists of re-establishing patent conduits through or about an occluded segment of artery by any one of a number of methods. The sympathetic nervous system approach is based largely on the effect of sympathectomy on the development of collateral pathways.

Means of Re-establishing Main Arterial Channels—

Three methods by which blood flow can be re-established to the area beyond an occluded arterial segment are: (1) thromboendarterectomy; (2) excision and replacement by graft or prosthesis; and (3) by-passing with graft or prosthesis.

1. Thromboendarterectomy consists of removing the occluding, organized thrombus with the attached intima and adjacent vessel wall, leaving a new lumen with a relatively smooth surface. The technique is demonstrated in Figure I. It is necessary to suture the intima

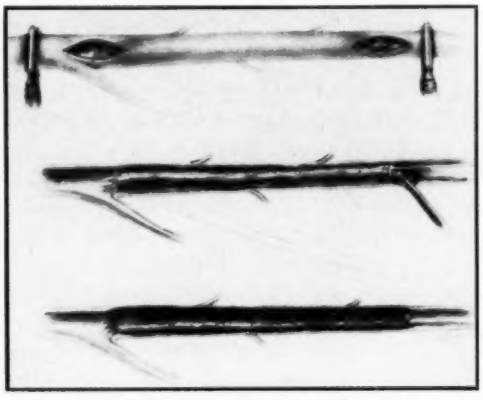

Figure I. Technique of Thromboendarterectomy. The upper drawing illustrates the two small incisions through which the procedure is performed. The middle and lower drawings are longitudinal sections of the artery, the middle figure showing a wire loop being used to separate the thrombus with attached intima and adjacent tissue from the remaining portion of the vessel, and the lower drawing illustrating a method of attaching the intima at the limits of the dissection to the vessel wall.

to the vessel wall, both proximally and distally at the points where the dissection was stopped. Essential for the success of this procedure is the presence of a good vessel distally through which blood can flow freely, otherwise the vessel will promptly become occluded by thrombus. Heparin is started during the operation and continued for a few days postoperatively. We have used the Mayo extraluminal vein stripper to "ream-out" the vessel without great success, but Cannon and Barker[2] report excellent results with a similar but more refined technique, with a low incidence of subsequent re-occlusion.

2. Excision and replacement by graft or prosthesis.

In this method the occluded segment of artery is excised up to, and down to, relatively good artery and the blood flow is re-established by anastomosis with a suitable length of vessel or plastic prosthesis. This method is usually less difficult technically than that of thromboendarterectomy and is less prone to lead to

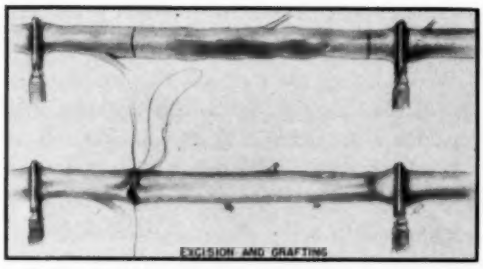

Figure II. After excising the segment between the dotted lines in the upper drawing, an alcohol-preserved homograft is being inserted into place below. A continuous over and over stitch is shown which should be of arterial silk, size 5-0 or 6-0, with a swedged-on atraumatic needle.

early thrombosis. The disadvantage of the various forms of grafts and plastic prostheses being used will be considered later.

Figure II illustrates the insertion of an alcohol-stored homograft after excision of an occluded segment of artery.

3. By-passing by graft or prosthesis.

In the process of excising an occluded segment of artery with enough margin on each end to reach an arterial wall suitable to use for anastomosis, it is frequently necessary to sacrifice one or more rather important collateral vessels. Subsequently, if the graft or prosthesis becomes occluded, the patient has less blood supply to the extremity than he had originally. To obviate this hazard, and to simplify the operative procedure, a shunt can be established about the occluded segment by means of a suitable graft or prosthesis leaving the occluded segment undistrubed. Without dissecting extensively, the upper end of the graft or prosthesis is joined to the host's vessel above the point of obstruction by an end-to-side anastomosis, and the lower end is joined similarly to the host's vessel below the obstruction.[3, 4]

Figure III illustrates this technique.

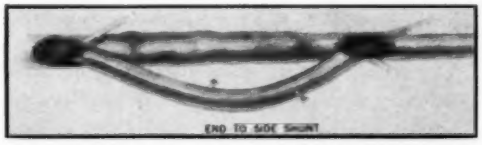

Figure III. A short shunt is illustrated here. Much longer occluded segments can be successfully by-passed with this technique.

Choice of grafts or prostheses—

The most generally accepted grafts are arterial homografts and autologous vein grafts. The usefulness of autologous vein graft is quite limited since its dissection prolongs the procedure and it is not suited to long replacements because of the poor fit resulting from turning the vein around so that its valves do not impede blood flow. Vein grafts may also be more prone to late thrombosis than arterial homografts.

Arterial homografts serve effectively for some years, although they are ultimately replaced completely by the host's own tissues and the elastic fibers eventually disintegrate. The rather burdensome method of preservation by the "freeze-dried" technique has been a deterrent to their common usage. However, our experience, and that of others, with alcohol stored grafts has been good, indicating that the more troublesome techniques required with "freeze-dried" methods may not be necessary. The possibility that alcohol-stored homografts have less antigenicity than grafts stored by other methods is being investigated in our laboratory. If the antigenic properties of heterografts can be destroyed in this manner, heterografts might be safely used. If by this or some other method, heterografts could be so altered that they serve as well as homografts, then the present difficulty of maintaining an adequate supply of grafts would be largely overcome.

Since the homografts are eventually completely replaced by the host's tissue, it would not be surprising to find at some future date, an aneurysmal dilatation at the site of graft in the aorta which might require removal.[5] A discouragingly high late thrombosis rate has been noted in homografts when used to replace smaller arteries.[6]

Plastic fabrics have been used as substitutes for the large vessels[7] because of the uncertainty of the long term results of homografts, and because of the difficulties in securing and storing adequate supplies of homografts. Technically, the various forms of plastics have worked well. They are relatively easy to construct in the desired shapes and

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sizes. A large assortment of shapes and sizes can be kept indefinitely and always available. Or they can be tailored to fit at the time of surgery, as demonstrated by Poth.[8] However, the ultimate fate of the various plastic substances when embedded within the body is uncertain. We have shown that some of them lose strength rapidly when embedded in the tissues of the dog. Poth has substantiated this in regard to nylon. Our unpublished results indicate that nylon, orlon and fortisan, as well as the natural fibers, silk and cotton, lose strength rapidly and are unsuitable because of this for use as substitutes for vessels. Vinyon "N" and dacron have to date shown little, if any, loss of strength.

It seems reasonable to assume that without the added support of elastic fibers or the plastic fibers of the prosthesis, fibrous tissue structures will be unable to withstand indefinitely the arterial pressure and pulsations to which arterial walls are continually subjected.

Promotion of development of collateral vessels—

Sympathectomy is probably the only practical surgical procedure which promotes the development of collateral vessels to an ischemic part. By releasing the smaller arteries and arterioles from the sympathetic impulses, it improves the blood supply to the extremity, particularly to the skin and, at least in some instances, to the deep tissues. Since sympathectomy stops sweating, the extremity becomes warmer due both to the improved circulation and to the absence of the cooling effect of evaporating sweat. Infections are made less likely because the common fungus infections of the foot, which frequently provide the avenue through which bacteria penetrate the protective covering of the skin, are favorably influenced by the dryness resulting from sympathectomy. Through this same mechanism, sympathectomy may be doubly valuable in patients with Buerger's disease.

Sympathectomy should be considered for those who warrant a surgical procedure to improve their circulation but who do not have a type of localized arterial occlusion which may be effectively treated by direct vessel surgery.

We no longer use routinely the preoperative test of blocking the sympathetic ganglia with procaine, since many patients who do not have a good response to the test will have a good result from sympathectomy.

The type of sympathectomy preferred is a unilateral lumbar sympathectomy, L1 through L4 or L5 inclusive. The extent is frequently limited to L2 through L4 because of the technical difficulty of removing the first lumbar ganglion, unless the removal of the first ganglion is thought to be specifically indicated by evidence of a high femoral occlusion. When the occlusion involves the iliac and lower aortic areas and is not amenable to direct vessel surgery, Grimson's suggestion[9] of extending the sympathectomy up to D8 or D9 has been utilized with very encouraging results.

In general, a unilateral sympathectomy is preferred if the symptoms are confined to one side or if the condition of one extremity is precarious. Unless contraindicated for medical reasons, a bilateral sympathectomy is performed if the symptoms are bilateral and there is no impending gangrene.

Sympathectomy is offered more freely for the diabetic than the non-diabetic. The diabetic is more prone to sudden catastrophy in an asymptomatic extremity due to his greater susceptibility to infection. It is not unusual to see a diabetic with good pulsations in the foot vessels, develop gangrene of a toe secondary to a minor abrasion or infection. The added benefit of a dry foot, which discourages epidermophytosis, is particularly valuable here. For these reasons, sympathectomy is usually bilateral for those who are diabetic, even though symptoms are present only unilaterally, unless contraindicated by the patient's general condition or by a very precarious condition of one extremity.

Our results from sympathectomy in those who enter with gangrene of one or two toes are considerably better in diabetics than in non-diabetics, in that we are more often able to prevent a major amputation.

Contraindications to sympathectomy—

Sympathectomy is contraindicated if there is little to gain from it and if, because of advanced coexistent disease, it imposes a considerable and greater risk than will be offset by its possible benefits. Although a lumbar sympathectomy is easy to perform and carries little risk either in morbidity or mortality,[10] it should be advised only rarely in those who are such poor risks that the mere prolongation of their hospital stay is apt to provide the time necessary for the development of more severe renal, cerebral, cardiac or pulmonary disease. If gangrene is already so extensive that a major amputation is necessary regardless of the possible benefits of sympathectomy, then it is better as a rule to procede directly with the indicated amputation.

Summary

Conservative measures, particularly good local care of the feet, will often prevent the catastrophies which are prone to occur in those with arterial insufficiency of the lower extremities.

The currently used methods of restoring the arterial blood flow to lower extremities are briefly reviewed. A prerequisite for any of the methods of direct vessel surgery to be successful is a sufficiently good arterial tree distally to allow a fairly good flow of blood. This necessity limits the applicability of direct vessel surgery and makes it necessary to resort to sympathectomy in many instances.

Longer periods of observation and more experimental work will be required before it will be possible to determine which of the presently available replacements for vessels is best from all standpoints.

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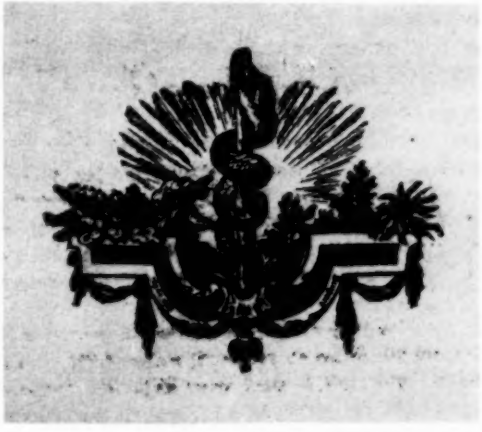

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CHEMICAL TREATMENT OF GASTROINTESTINAL CANCER

JOHN R. SAMPEY*
Greenville, S. C.

Cancer of the digestive tract is responsible for forty per cent of the cancer deaths in the United States each year. Efforts to control malignant tumors of the gastrointestinal tract in experimental animals have met with little success.[20] The present paper presents clinical studies with a score of agents in the search for some management of these neoplasms.

Chymotrypsin. Parenteral injections of this enzyme were without effect on adenocarcinoma of the stomach.[22]

Dichloroaminopterin. Branche, and associates,[3] reported no clinical benefits from the use of this drug on 10 patients with gastrointestinal cancer.

Polyden. Polyden therapy exerted little influence on carcinoma of the stomach.[8]

Krebiozen. The Council on Pharmacy and Chemistry of the AMA reported this agent failed to give any objective evidence of improvement in 21 patients with gastrointestinal tumors.[4]

ACTH. Wright, et al,[27] found this hormone was without significant value in altering the course of carcinoma of the digestive tract, and Postlethwait, et al,[17] reported no subjective or objective improvement in 6 patients with stomach carcinoma after ACTH therapy.

Cortisone. The latter group of investigators reported cortisone produced no improvement in patients with advanced carcinoma of the digestive tract, but Raab and Gerber[18] noted improved mental state, better nutrition and less pain in patients with carcinoma of the colon and pancreas after cortisone and ACTH therapy.

Viruses. Southam, and associates,[14, 23] found no gross or microscopic morphological change attributable to any of 11 viruses inoculated into patients with adenocarcinoma of the stomach and rectum. Later Southam and Moore[24, 25] described some regression of adenocarcinoma and adenoma of the gastrointestinal tract in patients injected with Egypt 101 virus.

Radioisotopes. Radiogold intracavitary therapy of patients with neoplasms of the stomach resulted in superficial damage only to tumors, as determined by autopsy.[10] Motsford, et al,[2] recorded hypoplasia of bone marrow in patients treated with Au^{198} for stomach cancer. Abdominal cancer responded little to radioactive phosphorus,[19] and tumors of the digestive tract were largely resistant to radiocobalt treatments.[5]

Aureomycin. A combination of parenteral aureomycin and irradiation in far advanced carcinoma of the large intestine resulted in some clinical improvement.[1]

Teropterin. Weintraub, et al,[26] described subjective improvement in 55 percent of the cases of advanced carcinoma of the stomach, lungs, breast, etc., following teropterin treatments, but they discovered no objective evidence of improvement.

Colchine. Eichler[6] obtained some palliation with colchine therapy on patients with inoperable stomach cancer.

Mercurized Indigo. Gore[7] reported increased survival rates for patients with adenocarcinoma of the lower bowel who received intravenous injections of mercurized indigo.

TEM. Lenti and Gavosto[11] secured some improvement with triethylene melamine therapy of gastric carcinoma, but Wright, et al,[28] observed little improvement in patients with stomach adenocarcinoma.

Citronellal and Nitromin. Osato, et al,[15, 16] prolonged the lives of patients with cancer of the stomach by administration of citronellal,

*Furman University

citral and the n-oxide of nitrogen mustard.

Liver Extracts. Maier-Bosse[12] recorded some improvement in patients with stomach carcinoma, following the use of liver extracts.

Vitamins. Massive doses of vitamins A and C induced some palliation in patients with gastrointestinal neoplasms.[21]

Phenol and Hypophyseal. Injections of phenol in glycerine or propylene glycol,[13] and hypophyseal implants[9] have been used to relieve chronic pain in carcinoma of the stomach.

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Primary Carcinoma of Bartholin's Glands. Edward J. Dennis, III, Lawrence L. Hester, Jr., and Lester A. Wilson, Charleston. Obstetrics & Gynecology. 6:291-296, September 1955.

Primary carcinoma of Bartholin's gland comprises 3 per cent of malignant growths of the vulva. The case reported is the 114th case in the literature and the first reported during pregnancy.

Epidermoid carcinoma and adenocarcinoma comprise the predominant cell type. Presenting symptoms in order of frequency are unilateral vulval mass, pain and tenderness, dyspareunia, abscess and draining sinuses, and pruritus vulvae.

Adequate therapy includes radical vulvectomy with bilateral radical groin dissection. Prognosis is poor as statistics on survival indicate a poor five year survival. Of the cases reported, there were only 9 five year survivals. Adequate surgery will undoubtedly increase the five year survivals.

Giant-Cell Tumor of the Pelvis at the Acetabulum, Ilium, Ischium, and Pubis. G. R. Dawson, Jr., M. D., Florence. J. Bone & Joint Surg. 37-a: 1278-1280, Dec. 1955.

This is believed to be the first case of aneurysmal bone cyst of the pelvis at the acetabulum reported in the literature (anuerysmal bone cyst was formerly included in that large waste basket classification of giant-cell tumor). The destruction of bone extended down to the acetabular cartilage, and the continuous wall of the lesion extended to the mid-line. At operation, the lesion was curetted and was packed with small one-fourth inch bone chips obtained by removing a good portion of the iliac wing. The bony lesion and cyst wall healed as a solid bony mass. The patient walked with a limp. Four years later, the patient became pregnant. A cesarean section was done as the healed bony mass extended to the pelvic midline and blocked the pelvic outlet.

Pelvic Plastic Repair—Indications and Results. Wilson, J. M. (Charleston) Am. J. Obst. & Gynec. 70: 1219-1224, Dec. 1955.

Sixty-nine patients treated surgically for prolapse, cystocele, rectocele, enterocele and stress urinary incontinence were followed up to 7 years. The procedures performed were vaginal hysterectomy or colpocleisis or both.

There were no deaths. There were ten operative complications, none serious. Post-operative complications were largely urinary tract infections, none serious. Previous pelvic surgery including ventro-fixation, was not thought to be a contraindication to the vaginal approach.

There were 5 symptomatic recurrences (all within the first year) with the patient dissatisfied.

It is thought that the procedures carry moderate risk but that the end results justify this.

PECTUS EXCAVATUM

FURMAN T. WALLACE, M. D., SAMUEL T. ELMORE, M. D. AND RICHARD S. WILSON, M. D.

Spartanburg, S. C.

Pectus excavatum or severe "funnel breast" can be a quite disabling as well as a disfiguring condition. The malplacement of the lower part of the sternum back to the region of the vertebral column displaces the heart to one side with sometimes serious effects. A paradoxical inward motion of the lower sternum develops producing a paradoxical respiration. As the child grows, the extreme limitation of chest expansion produces other skeletal abnormalities.

The technique of correction was standardized by Ravitch.[1] The correction is accomplished by removing all of the costal cartilages in the region of the defect, detaching the xiphoid process from the sternum, and cutting all of the attachments of the sternum up to the third interspace. A transverse sternotomy is done through the anterior cortex, correcting the posterior displacement.

Controlled positive pressure endotracheal anesthesia is essential and makes the procedure possible.

Case Report: Spartanburg General Hospital No. 86726. A 12 months old white male was admitted to the Spartanburg General Hospital on Jan. 30, 1955 with a severe pectus excavatum. Paradoxical respiration was present. The heart was displaced to the left side of the chest.

On Feb. 1, 1955 operation was done. Anesthesia was endotracheal ether by a non-rebreathing technique with a Slater-Stephen valve by Dr. Charles H. Poole. A mid-line incision was made from the suprasternal notch to the epigastrium. The sternum and deformed costal cartilages were exposed. All of the cartilages in the region of the defect were removed. (Fig. 1)

The xiphoid process was detached from the sternum and excised. The recti muscles were allowed to retract. A transverse sternotomy was done. (Fig. 2). and the sternum elevated anteriorly, over-correcting the defect. The anterior cortex of the sternum was sutured along with the periosteum with interrupted cotton sutures. The pectoralis major muscles were reattached to the sternum.

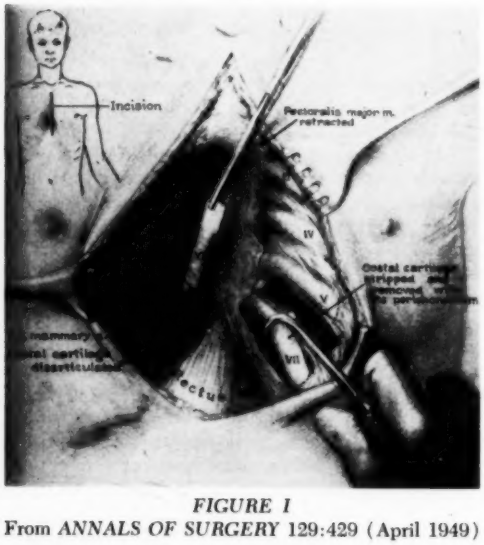

FIGURE I
From *ANNALS OF SURGERY* 129:429 (April 1949)

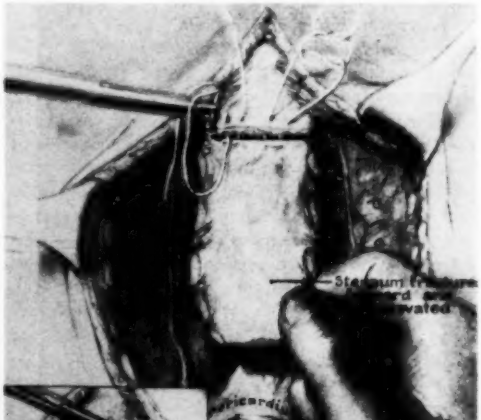

FIGURE II
From *ANNALS OF SURGERY* 129:429 (April 1949)

From the Departments of Surgery and Pediatrics, Spartanburg General Hospital, Spartanburg, S. C.

The post-operative course was uneventful and an excellent cosmetic and functional result was obtained. (Fig. 3).

DISCUSSION: The technique as evolved by Ravitch[1] was closely followed. In this case it was more convenient to remove the xiphoid cartilage rather than detach it and allow it to retract downward to the mid-portion of the epigastrium.

In Ravitch's original report and in this case, no particular attempt was made to preserve the perichondrium. In a later presentation,[2] Ravitch mentioned that the perichondrium can be preserved with surprising ease and an earlier post-operative stabilization of the chest wall results.

SUMMARY: Pectus excavatum can be a disabling condition. It is correctable by a logical orderly operative technique. An illustrative case is presented.

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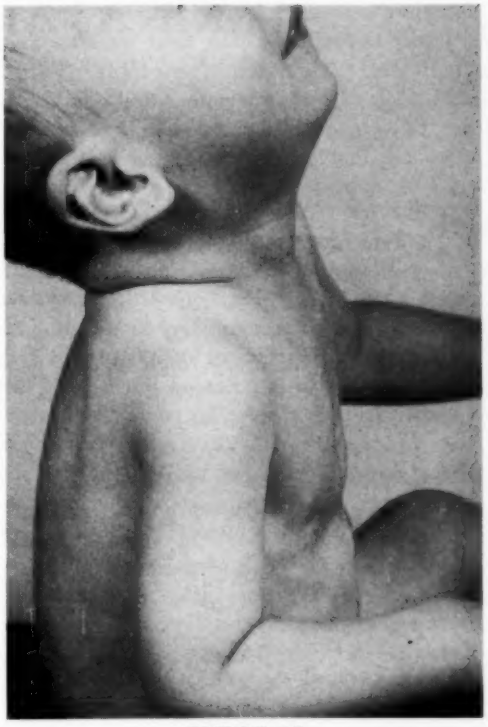

FIGURE III
Post-operative Result

Vitiligo and Pernicious Anemia. Allison, J. R. and Curtis, A. C. Arch. Dermat. and Syph. 72: 407-408, November 1955.

A statistical analysis 801,678 admissions to the University of Michigan Hospital was done to substantiate the suspicion that pernicious anemia was not uncommon in patients with vitiligo. There were twenty-two patients with the combined diagnosis of pernicious anemia and vitiligo in this survey, whereas the calculated theoretical occurrence of the combined diagnosis was less than one case. 4.1 per cent of the cases with vitiligo had pernicious anemia. Only 1.6 per cent of the patients with pernicious anemia had vitiligo. This lends credence to the clinical observation that pernicious anemia occurs more frequently in patients with vitiligo than should normally be expected.

Simultaneous Occurrence of Duodenal and Gastric Ulcer during Therapy with ACTH. A report of two cases. Baroody, W. G., and Shugart, R. T. Am. Pract. 6:1876. Dec., 1955.

Report of the simultaneous development of gastric and duodenal ulcers in each of two patients having Boeck's Sarcoid treated with ACTH. Neither patient had a history remotely suggestive of previous peptic ulceration and gastrointestinal roentgenograms prior to therapy were normal. Case 1. 22 year old Negro male was started on 20 mgm. ACTH intravenously scheduled daily for 28 days then reduced to 15 mgm. daily for 6 days and subsequently, 10 mgm. daily for 5 days. Therapy was discontinued during the 5th week because of epigastric pain typical of peptic ulceration. Radiological study revealed a small gastric ulcer high on the lesser curvature, and as a duodenal ulcer.

Case 2. 22 year old Causcasian male, was started on the same ACTH therapeutic schedule, but this had to be discontinued after 5 days because of epigastric pain which was characteristic of peptic ulceration. Gastrointestinal roentgenograms revealed a gastric ulcer in the antrum, and a duodenal ulcer.

Both patients were treated with modified Sippy diet, antacids and atropine. Healing occurred uneventfully in 6 weeks and 3 weeks in the respective patients. Some if the theoretical etiological mechanisms are briefly discussed.

Prophylactic anti-ulcer therapy was recommended for any patients receiving prolonged steroid therapy, and for all patients receiving steroids who have a previous history of peptic ulceration.

PERINATAL MORTALITY

I — THE ROLE OF PREMATURE BIRTH

J. Decherd Guess, M. D.
Greenville, S. C.

The term perinatal mortality is used to refer to the deaths of infants which occur shortly before, during, or shortly after birth. Gold[2] has reported a study of perinatal deaths occurring in New York City in 1946-1953. In that series, 90 per cent of early infant deaths occurred during the first month of life and over 50 per cent occurred within 24 hours of birth. Ninety per cent of these deaths were due to perinatal causes. These perinatal deaths were divided by Gold into groups shown in table I.

TABLE I

PERINATAL CAUSES OF EARLY INFANT DEATHS

1. Prematurity (under 5½ lbs.)	51%
2. Injuries and malformations	15%
3. Anoxemia or erythroblastosis	11%
4. Ill defined and unknown causes	41.6%

This study indicates that, although several contributory causes of perinatal deaths exist, premature birth with its associated problems is the leading cause and that it ranks among the leading causes of human mortality generally. Preventive measures directed primarily to lowering the incidence of prematurity and toward reducing the mortality associated with it should favorably influence perinatal mortality.

Factors believed to influence length of gestation up to term include nutrition and general health of the mother during pregnancy. Since nutrition is one of these factors, the economic status of the family and personal and family food habits play an important role in the problem of premature births. The general health of the expectant mother is more nearly a medical problem. Medical guidance and early treatment of deviations from normal good health are necessary throughout pregnancy to insure the best physical and emotional health.

Since the incidence of premature labor is greatest in Negroes, in gravida under 20 years of age, particularly in young multi-gravida; and in plural pregnancies, it is these women who offer the greatest opportunity for improvement by adequate prenatal care in its broadest application.

In discussing the importance of prenatal care in relationship to the problem of premature delivery, Carrington[1] states: "Systemic, emotional, metabolic and genital factors which may be related to premature labor should be looked for. They frequently are not obvious."

Physical good health is important in allowing conception, in preserving pregnancy to term, and in providing a healthy baby. Maternal ills which necessitate premature, deliberate termination of pregnancy give rise to many neonatal deaths. The survival rate of infants born before the thirty-second week of gestation, calculated from the date of the last menses, is less than 50 per cent. This indicates that the time of probable viability of the baby is not reached until after the eighth intrauterine month. Thus, it is true that the judicious management of the complications of pregnancy so as to extend the intrauterine life of the fetus, should result in lower perinatal mortality.

Just what influence mental and emotional disturbances have on perinatal mortality has not been accurately evaluated. A happy, enthusiastically expectant mother tends to experience fewer complications of pregnancy and labor than one filled with worries and anxieties. If in addition to a happy disposition, she is also intelligent, she is able to cooperate helpfully in her medical care.

Metabolic disorders may be significant in causing premature labor. An abnormal metabolic rate may be the only evidence of such disorder.

Hyperthyroidism increases the tendency toward premature labor. Formerly, it at times became a valid indication for therapeutic

abortion. Now treatment of hyperthyroidism in pregnant women is strongly indicated. Such treatment, including thyroidectomy, does not disturb pregnancy and it should not be delayed solely because of it.

Hypothyroidism, even without definite clinical symptoms, and whether associated with colloid goiter or not, often results in premature labor as well as in cretinism and congenital goiter in the child. Treatment with thyroid extract is definitely indicated in gravida with even subclinical hypothyroidism.

Prophylactic efforts to prolong pregnancy to term should be directed not only toward maintaining good nutrition and generally good health for the mother. There are at least five specific and frequent causes of premature birth. They are listed in table II.

TABLE II

SPECIFIC AND FREQUENT CAUSES OF PREMATURE BIRTH

1. Antepartum hemorrhage
   a. Placenta previa
   b. Abruption of placenta
2. Hypertensive toxemia
3. Premature spontaneous rupture of membranes
4. Repeat cesarean section
5. Multiple pregnancy

There is no way to prevent placenta previa, and it is rarely recognized before serious hemorrhage has occurred. However, it should be thought of and an effort made to rule it out when even minor hemorrhage occurs in the third trimester of pregnancy. Rarely is the first significant hemorrhage caused by placenta previa fatal or even immediately hazardous. When it occurs before probable viability of the fetus, an effort to continue the pregnancy is justifiable. Such early bleeding is no longer a firm indication for cesarean section. The increasing proximity of hospitals with increasing availability of blood for transfusion seems to make that statement sound.

The patient who has her first bleeding episode before viability of her baby should be blood typed and if her hospital does not maintain a blood bank, suitable donors should be arranged for. Although further hemorrhage cannot be prevented by bed rest and sedatives, relative inactivity, sedatives and the avoidance of sexual excitation tend to prevent serious and dramatic hemorrhage.

Abruption of the placenta is frequently immediately fatal to the infant. It tends to occur near term. If not rapidly fatal to the baby, the baby often may be salvaged. Since abruption is frequently associated with toxemia of pregnancy, the recognition and active treatment of early toxemia is, perhaps, the best prophylaxis.

Every abruption of the placenta is not an indication for immediate cesarean section. If the baby is already dead or is hopelessly premature, there may be no indication. However, the writer does not practice or advocate expectancy in cases where the bleeding is severe and continuous, even though the baby be dead. He realizes that in such cases, the mother usually can be saved by large and continuous blood transfusions, and delivery can be accomplished from below. He also believes that fetal salvage may be as good as that in delivery by section. However, it is his feeling that once delivery is indicated, danger to the mother is lessened, danger to the baby is no greater, and apprehension of the patient and her family is greatly lessened by section—all with a saving of precious human blood.

Toxemia of pregnancy, either severe preeclampsia or eclampsia, is the leading cause of death of pregnant women. Because that is true, it is probably the leading cause, either directly or indirectly, of perinatal deaths. The situation will not be improved until doctors and patients realize the serious implications of the earliest signs of toxemia and the necessity for vigorous medical treatment and for close and frequent observation. When recognized early and treated properly, pregnancy frequently may be continued until the baby is surely viable. Cesarean section in cases of toxemia is rarely undertaken in the interest of the child and rarely is it indicated in the interest of the mother with eclampsia.

Premature rupture of the membranes, followed by labor, has been reported to cause up to 20 per cent of all premature births. Statistics indicate further that premature rupture of the membranes occurs more frequently in poor economic groups and especially in Negro mothers. No satisfactory explanation of this

accident of pregnancy has been determined. Some believe that an abnormal condition of the amniotic membrane is always responsible. Others think that chronic cervical infections are a factor. Others blame it on coitus, or upon other physical stress and strain.

It is the feeling of the writer that physical labor and coitus late in pregnancy are both frequent factors. The type of presentation is often the determining factor. Emotional tension and apprehension, with an accompanying tendency to severe Braxton Hicks contractions, frequently result in premature rupture, especially in cases where hard work and frequent coitus have resulted in early cervical dilatation. Breech presentation, especially footling breech and a transverse lie do not protect the membranes from increases in intrauterine pressure when those membranes overlie a partially dilated cervix.

Rupture of the membranes before certain viability of the child is a serious accident. When pregnancy is near term, labor usually ensues within a few hours, regardless of the treatment employed. In earlier pregnancy, labor may not begin for days or even weeks after premature rupture. In these cases, no effort should be made to start labor. The dangers of lapse of time between membrane rupture and delivery have been greatly lessened by availability of broad spectrum antibiotics. The most serious danger in premature rupture has always been to the child. Pulmonary infections have killed these infants before death from prematurity occurred. The broad spectrum antibiotics have been shown to traverse the placental barrier and to afford significant protection against fetal pulmonary infection.

Next to infections and non-viability, the greatest hazards to the premature infants occur during labor and delivery. These include trauma. However, anoxia is an even greater hazard. These children are peculiarly susceptible to the respiratory depressant effects of all sedatives, amnesia-producing drugs, and all systemic anesthetics. This sensitivity is out of all proportion to the weight and the degree of prematurity. It is true with regard to any single drug, but it is exaggerated when drugs are used in combination or succession. Little if any such drugs should be given in any stage of labor, and local perineal infiltration, pudendal block, or saddle block should be used terminally if needed. Were the seriousness of the risk to the child of anesthesia and analgesia given the mother more generally recognized by obstetricians, the mortality from prematurity would be significantly lessened.

Repeat cesarean section is included in the causes of perinatal deaths, and its discussion is included in that of deaths from prematurity. What has been said regarding danger of anoxia applies to infants delivered by section. When elective cesarean section has been determined to be the preferable method of delivery, great care should be exercised to avoid premature delivery. The menstrual history is not always a reliable guide to the length of gestational life. It is wise to consider all indications bearing on maturity before section is undertaken. These include the date of the last menses, the size of the uterus at the time of the first examination, the date of quickening, the apparent size of the baby at the time of proposed operation, and the condition of the cervix at that time. Danger of uterine rupture in a pregnancy following a delivery by cesarean section is greater before the onset of labor rather than after labor has begun. The risk of uterine rupture is not seriously increased by postponing section, even up to the onset of early labor, when there is a question as to the prematurity of the baby.

The final cause of premature labor to be discussed is multiparity. The condition itself cannot be prevented. However, labor often may be delayed by restricting strenuous activity, coitus, laxatives, automobile riding and emotional upsets. Even at term, babies of multiple pregnancies are usually lighter than average term babies, so that the degree of maturity cannot be determined by their weights. Prognosis cannot be so determined. Quite frequently small twins are normally mature and cause no difficulty.

Summary

An attempt has been made to classify the

causes of perinatal deaths. These causes have been divided into maternal and fetal and into antepartum and intrapartum causes, and the role and causes of prematurity have been discussed in some detail.

In a subsequent article, the causes of antepartum and intrapartum deaths will be discussed.

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2. Gold, E. M.: Perinatal Mortality, J. A. M. A., 159: 244, Sept. 24, 1955.
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ELECTROCARDIOGRAM OF THE MONTH* – ACUTE MYOCARDITIS

DALE GROOM, M. D.**
Charleston, S. C.

Case Record—A 7 year old negro boy was admitted to the Pediatric section of Roper Hospital with a history of having had a sore throat, fever, and cough of two weeks duration. Apparently at the onset of the illness it had been noted by the family that the child had some difficulty in swallowing and that his neck was swollen. One of them had looked in his throat, discovered a whitish membrane in the region of the uvula and painted the membranous tissue with iodine. Shortly thereafter the child was said to have coughed out a "wad" of tissue with subsequent drainage of a large amount of bloody purulent material from the throat. According to the patient's mother he had become increasingly lethargic, had a grunting type of respiration at night and was observed to be somewhat dyspneic at times. Three days prior to admission it had been discovered that the child's face, abdomen and scrotum had become swollen.

Interrogation of the family established the fact that this child had received no immunizations other than a pre-school vaccination for small pox.

Examination revealed an extremely lethargic child with evidence of generalized anasarca, ascites, pleural effusion, enlargement of the liver and edema of the scrotum. The heart was regular at a rate of about 140 beats per minute with the apical impulse diffuse and displaced to the left. No murmurs were audible.

X-ray studies revealed a generalized cardiac enlargement with pulmonary congestion and pleural effusion. Laboratory studies were not remarkable except for a persistent 4+ albuminuria and a slight leukocytosis. Throat cultures were negative for virulent C. diptheriae and beta streptococcus, as were cultures made from the patient's available family contacts. The Shick test was negative, indicating some acquired immunity to the diphtheria antigen (which could have been acquired at any time in the past, but might well have resulted from diphtheria two weeks before admission).

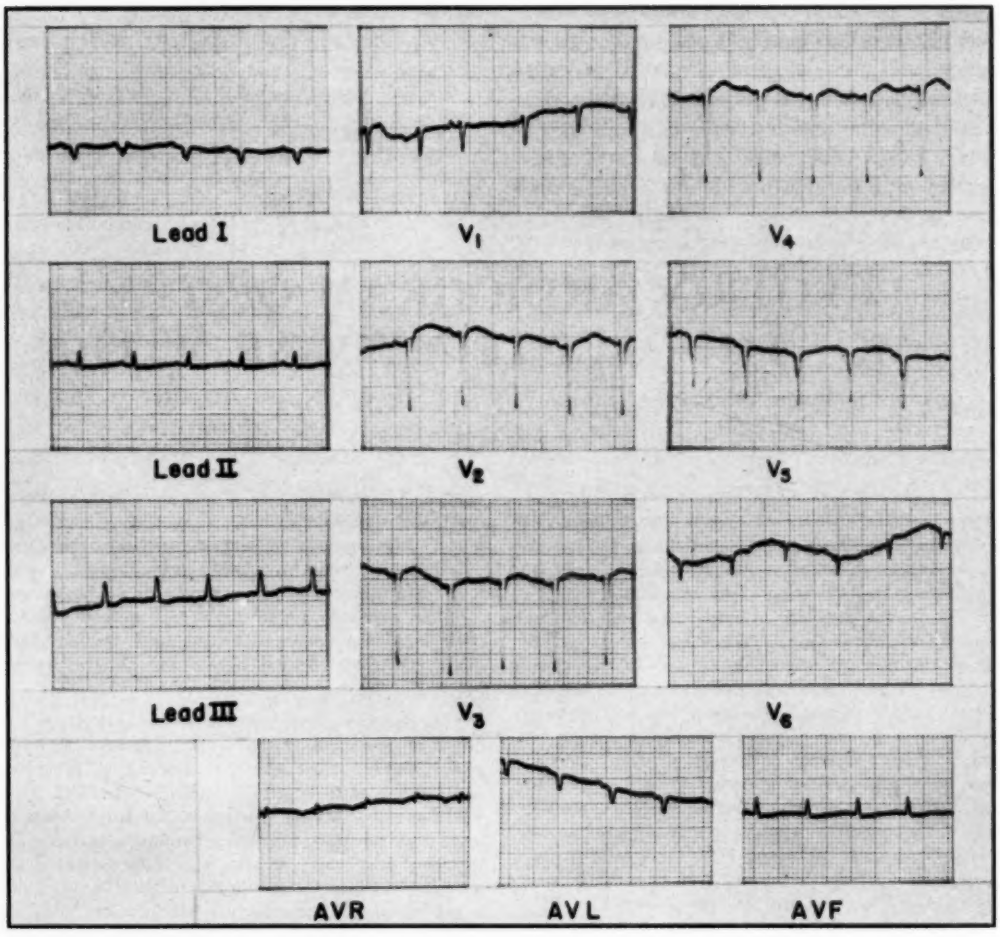
This patient's clinical course was characterized by profound weakness, tachycardia, evidence of congestive failure which failed to respond to digitalis, and absence of fever. After about one month of hospitalization he showed gradual improvement, became more alert mentally, and the albuminuria and edema subsided. His heart size and pulse rate decreased to normal. Two months following admission he was able to get out of bed and walk without dyspnea.

Electrocardiogram—The electrocardiogram shown below was taken the day of admission to the hospital. Notable is the almost complete absence of R waves in the precordial leads with only a QS deflection in V-5. The T waves show non-specific changes being flat, diphasic, or inverted in most leads. An upright QRS deflection in lead aVf with downward deflections in aVr and aVl indicates a vertical electrical axis producing the picture of right axis deviation in the standard leads. Voltage of all deflections is low in the standard leads, the QRS measuring 5 mm. or less. There may be some variation in the pacemaker occasionally but the P waves are inconspicious in most leads. A sinus arrhythmia exists with the rate varying from 140 to 150 per minute.

On subsequent electrocardiograms the T waves became inverted in all leads. Gradually during the twelve week period of hospitalization normal R waves appeared in the V leads, an upright QRS developed in lead 1, and at the time of dismissal from the hospital the patient's electrocardiogram was within normal limits.

*One of a series of clinical-electrocardiographic correlations. Purpose of this series is the presentation, not of necessarily rare or unusual ECGs, but of those which illustrate basic electrocardiographic principles or which contribute prominently to the clinical diagnosis.

**Asst. Professor of Medicine, Medical College of S. C. From the Department of Medicine, Medical College of S. C., and the Roper and Medical College Hospitals, Charleston, S. C.



Discussion—This electrocardiogram would ordinarily be interpreted as indicating anterior myocardial infarction. While it does not show any appreciable displacement of the ST segments it is probable that such existed during the two week interval prior to admission to the hospital. Furthermore the T wave inversions which developed in subsequent tracings were indistinguishable from those which are ordinarily seen following myocardial infarction. Such a diagnosis is of course not ordinarily tenable in a patient 7 years of age. Other possibilities that might be considered on the basis of the electrocardiogram alone are neoplasm of the myocardium, congenital absence of the left coronary artery, and acute myocarditis—all of which are capable of similarly impairing the electrical activity of the ventricles as recorded in the precordial leads.

It is now well recognized that many acute infections have their counterpart in inflammation of the myocardium. Diphtheria, typhoid fever, meningitis, pneumonia, and some virus infections such as encephalitis and poliomyelitis have been shown to involve the myocardium at times even to a fatal extent. Occasionally the inflammatory reaction is quite localized as in this case in which a large portion of the anterior wall appears to be electrically inactive, although the usual picture is one of diffuse widespread involvement with low voltage deflections and non-specific T wave changes. Mural thrombosis with embolization from such an area of myocardial

damage has been known to occur. The restoration of normal R waves in later tracings suggests considerable reversability of the inflammatory process in this case.

Diphtheritic myocarditis with nephritis was considered a likely cause of this child's illness although that diagnosis could not be established. A viral etiology was deemed as likely. The patient's convalescence was uneventful and, on follow-up examination two months after dismissal from the hospital he showed no residual cardiac abnormalities.

Venous Hum in Cardiac Auscultation. Dale Groom, M. D., John A. Boone, M. D., and Margaret Jenkins, M. D., Charleston, S. C. (J. A. M. A. 159: 639-641, Oct. 15, 1955)

The venous hum is a physiological extracardiac murmur heard in a high percentage of children and in some adults. It is characteristically a continuous murmur with accentuation during diastole. From its point of maximum intensity in one or both supraclavicular fossae it is frequently transmitted downward over the precordium where it may simulate remarkably murmurs of pathological significance.

The nature of the venous hum sound, as portrayed oscilloscopically, is described with particular reference to its diastolic accentuation and its comparison to the murmur of patent ductus arteriosus.

Recognition of this adventitious sound arising in the jugular veins is of importance in cardiac auscultation chiefly from the standpoint of differentiating it from pathological heart murmurs.

Characteristically, the venous hum on auscultory examination is accentuated by:

1. *Light* pressure of the stethoscope over the jugular vein.
2. The patient's assuming a sitting or erect position.
3. Turning the patient's head *away* from the side of origin of the hum and raising the chin.
4. The inspiratory phase of respiration.

Conversely, the venous hum is diminished or abolished by:

1. *Firm* pressure by the finger or stethoscope over the jugular vein.
2. The supine position of the patient.
3. Turning the patient's head *toward* the side of origin and lowering the chin.
4. The expiratory phase of respiration.

On the basis of these simple maneuvers the venous hum may be readily differentiated from other precordial murmurs.

Acute Cardiac Tamponade, A Complication of Sternal Marrow Aspiration. Jenkins, L. B., Ferrara, B. E. and Snead, H. P. A.M.A. Arch. Surgery 71: 892, 1955.

Thirteen deaths following sternal puncture have been reported in the world literature in the past 11 years. When performed, autopsies on these cases have shown acute cardiac tamponade to be the cause of death. The present report of a case of cardiac tamponade following sternal marrow aspiration is the first reported case in which the diagnosis was made and in which the tamponade was successfully treated.

The case presented was a 24 year-old Negro male admitted with chronic glomerulonephritis and hypertension. A sternal puncture was performed in the investigation of a severe anemia. The patient experienced some distress initially, but 6 hours elapsed before the classical signs of acute cardiac tamponade occurred. Such a delay suggested that the source of the intrapericardial blood was a site of low pressure oozing, such as the auricles, intrapericardial veins, or retrosternal veins. The cardiac tamponade was successfully relieved by 2 pericardiocenteses, removing a total of 215 ml. of blood. Careful observation for recurrence of the tamponade was made in the 23 days that the patient lived after the pericardiocenteses, but at no time was it implicated in the progression of renal failure and hypertension which lead to his death.

It is suggested that immediate pericardiocentesis be performed in the patient exhibiting signs and symptoms of a failing circulation after sternal puncture.

MEMBERS DECEASED

Name	*Address*	*Date of Death*
Dr. George T. Mansel	Spartanburg	
Dr. Robert E. Seibels	Columbia	May 30, 1955
Dr. Joe P. Jewell	Piedmont	June 18, 1955
Dr. Paul A. Smith	Spartanburg	August 3, 1955
Dr. William S. Bethea	Latta	August 23, 1955
Dr. A. Harry Niell	Clover	August 25, 1955
Dr. Vance W. Brabham, Sr.	Orangeburg	August 28, 1955
Dr. Dennis C. Stoudenmire	Honea Path	September 4, 1955
Dr. Arthur W. Browning	Elloree	September 28, 1955
Dr. William O. Self	Columbia	September 29, 1955
Dr. William A. Hood	Hickory Grove	October 4, 1955
Dr. Coyt Ham	Columbia	October 15, 1955
Dr. Henry Potozky	Columbia	October 23, 1955
Dr. Charles P. Benson	Landrum	November 17, 1955
Dr. John H. Mathias, Sr.	Lexington	November 19, 1955
Dr. Reyburn W. Lominack	Newberry	November 22, 1955
Dr. Joseph L. Powe	Hartsville	November 24, 1955
Dr. Samuel A. Morrall	Graniteville	December 14, 1955
Dr. J. William Haynie	Belton	December 19, 1955
Dr. Martin Crook	Spartanburg	December 21, 1955
Dr. Thomas A. Murrah, III	Rock Hill	December 22, 1955
Dr. William H. Price	Charleston	December 30, 1955
Dr. Frederick L. Webb	Clinton	January 10, 1956
Dr. Lawrence Manning Hook	Eastover	January 17, 1956
Dr. J. Wilson Ratliffe	Anderson	January 31, 1956
Dr. Ernest Z. Truesdell	Bethune	February 14, 1956
Dr. Theodore E. Bowers	Charleston	February 19, 1956
Dr. J. Sumter Rhame	Charleston	March 4, 1956
Dr. Edward W. Barron	Columbia	March 14, 1956
Dr. Joseph L. Shepard	Jefferson	April 14, 1956

MEMORIAL ADDRESS—1956

C. R. F. Baker, Chairman
Memorial Committee

"What we hold in memory is ours forever", and today we are here to keep memory green for those of our colleagues who have died during the past year. To each of us present the occasion is poignant with sadness, for who is there among us who has not lost some close and beloved friend? Some we knew by sight, some by name, and still others intimately—a part of the fragment of our daily lives. Thus we are bound today by a mutual sorrow in their passing, and by searching and troubled thoughts of the closing of the full circle. These men who have died were consecrated to the profession of medicine, in which we, too, feel a common devotion. The solidarity of our profession is one of its strengths, and no profession is bound by stronger ties or by greater faith in spiritual values above the material.

A wise doctor once said that in his experience some of the best work in the world was often done by people suffering from some bodily affliction. Though many of these men were ill and must, therefore, have had some sense of the dreadful shadow ahead, they still gave of their vitality, time, and strength, and some have gone before their time. "Not length of days but use of days" is a fitting epitaph for those who ministered to the sick at the expense of their own health and longevity. In their youth, in choosing medicine, they also chose a way of life, and they kept their original and eager devotion to their profession till death. Thus we honor them today from a full heart—for their going has left us with a sense of waste and loss. How we have missed them, how we still must miss them in some-

thing I'd rather not go into in my mind. As the poet, Edna St. Vincent Millay wrote to a friend after the death of her husband, "Yes, it must indeed seem impossible to you that he will not be coming down the hill to fetch the mail this lovely autumn day. He never comes up the hill either, anymore."

But, this must be our consolation, their deaths are not the end. Dr. Harvey Cushing expressed this well when he wrote about the loss of several beloved doctor friends, "Though lives die, the life is not dead, and the memory of lives such as these will be reverently shared, not by a profession alone, not by a nation alone, but by the universal brotherhood of man." The bright, cherished memory of our colleagues and their works will endure, and it will sustain us.

Prophylactic Use of Quinidine Following Myocardial Infarction. Boone, J. A., & Pappas, A. South. M. J. 49:169-172, Feb. 1956.

The effect of the use of quinidine and anticoagulants on the mortality following myocardial infarction was studied in the records of 190 patients in Roper Hospital.

Of 190 patients, 54 died, a gross mortality of 28 per cent.

Of 90 patients receiving anticoagulants, 21 died, a mortality of 23 per cent. Of 100 untreated, 33 died, a mortality of 33 per cent. The reduction in mortality with anticoagulants was approximately one-third.

Of 63 patients receiving quinidine, 10 died, a mortality of 16 per cent. Of 127 patients untreated, 44 died, a mortality of 35 per cent. The reduction in mortality with quinidine was approximately one-half.

It is suggested that the routine prophylactic usage of quinidine sulfate in dosage of 0.2 gm. every three hours while awake may be an effective means of reducing the mortality from myocardial infarction.

Electrocardiographic Changes Following Adrenalin. Wilson, Robt. Tri-State M. J. 3:28-30, Dec. 1955.

A case is reported of electrocardiographic changes following the inadvertant injection of 6 ml. of a 1:1000 solution of adrenalin chloride. The mistake was found after 6 ml. had been infiltrated into the tonsillar area: The blood pressure rose to 240/160, later falling to shock levels. An electrocardiogram taken shortly thereafter showed sagging of the S-T levels in many leads, which changes were thought compatible with a severe degree of sub-endocardial ischemia or thrombosis: Further electrocardiograms, later the same day and thereafter, were all within normal limits. The patient made a complete and uneventful recovery and has remained in good health since that time.

Calcified Cyst of Spleen, Report of a Case. Wolfe, Albert B. Am. Surgeon 21: 1141-1145, Nov. 1955.

Cysts of spleen are classified as: (1) echinococcic, (2) dermoid, and (3) nonparasitic. The latter is subdivided into true and pseudo cysts among which the rare calcified cyst is included. The etiology and pathogenesis are poorly understood. There is frequently an associated history of trauma to the spleen. It appears that trauma and diseases which cause vascular occlusion result in infarction, necrosis, and hemorrhage. Resorption of necrotic splenic pulp follows with cyst formation.

These nonparasitic cysts vary in size and contents, and some may or may not have endothelial lining cells. Diagnosis is made by presence of upper left abdominal pain and a mass. Roentgenograms may reveal pressure defects of the stomach and colon and downward displacement of the left kidney. A case report is given of a calcified cyst of spleen with history of trauma ten years previously, with successful splenectomy and recovery. Review of literature through 1954 places the number of nonparasitic cysts at 202 and of calcified cysts including this case at 37.

Evaluation of Polyvinyl Pyrrolidone as a Plasma Expander. Jenkins, L. B. Kredel, F. E. and McCord, W. M. Arch. Surg. 72: 612, 1956.

Polyvinyl pyrrolidone was evaluated in 97 patients as a means of expanding the plasma volume as measured by the hematocrit and Evans blue dye or clinical response in hypotension. The intravenous injection of polyvidone caused an expansion of the plasma volume which disappears in 20-24 hours in the average case. The hematocrit fell an average of 5.8 volumes % 3-5 hours after an infusion of 1000 ml., with a gradual return to the normal range at the end of 24 hours. However, hemodilution persisted for 48 hours or longer in 20% of the patients. When determined by the Evans blue dye method, the plasma volume increased about one-half of the amount of polyvidone given. The total available fluid, as measured by the thiocyanate method, showed an average rise of three times the amount of polyvidone infused. It is suggested that the increase in total available fluid beyond the amount of polyvidone given is due to the retention of ingested fluid and an internal fluid shift from the intracellular space. No local reactions were observed. One instance of chill and one case of pulmonary edema from too rapid administration were the only constitutional symptoms noted.

PRESIDENT'S PAGE

The honor of being president of the South Carolina Medical Association is fully appreciated. The responsibility which goes with it somewhat frightens me. I accept it as a challenge and as an opportunity. I shall endeavor to use the office for the purpose of improving medical care in South Carolina. This can best be accomplished by further increasing the strength of the State Association. While the purpose of the State Association is to serve the medical profession, it has also an obligation to the public. There is no conflict between the two. The medical profession should look to it for leadership and guidance in matters pertaining to professional welfare. The public should look to it to promote general medical welfare and in particular to protect it from the selfish interests of various groups and the profession as a whole. While there are a number of societies both general and special, whose interest is devoted primarily to medical education, on the other hand the field of ethics, policy and public relations is peculiarly that of the State Association. Through a State Association which has the complete confidence of the public, the medical profession can best express its aims and present its position on matters of general interest. A strong State Association is to the best interest of the public and the medical profession. To attain this, the support of each and every one of us is necessary.

W. H. PRIOLEAU

Editorials

PRESIDENTIAL SUCCESSION

The Association has passed through a very successful year under the able leadership of Dr. O. B. Mayer. Progress has been made in all directions and business has been transacted harmoniously. Now there comes to the chair Dr. W. H. Prioleau of Charleston, a man of proven executive ability and sound judgment. Under his gavel the affairs of the Association should prosper plentifully.

Dr. Mayer is the son of a former president of this Association. Dr. Prioleau is the stepson of a former president, Dr. E. F. Parker. And our president elect, Dr. D. L. Smith, is the son of former president Dr. D. L. Smith. The impulse to leadership persists in our medical families.

FEES AND SERVICES

A new effort to establish a systematic guide to proper charges is being made by the California Medical Association. This is not an attempt to set relative values on the services of the several branches of the profession, but a proposal to place relative values on the various services of any one branch—for example, to have the individual physician set a unit charge for a house call in the day and by a formula determine the fee for a night call, or to have the surgeon set a charge for an appendectomy and by simple arithmetic decide what a more elaborate operation should be worth.

This system should be useful in setting up more definite and perhaps more acceptable fees. It does nothing to solve the question of inequalities in returns for services rendered by different branches of the profession.

THE HOXSEY CLINIC

The Food and Drug Administration has taken an unusual and laudable step in condemning officially and publicly the Hoxsey cancer clinic which for years has been carrying on a booming business in cancer pills and other cancer "cures". An injunction against shipment of Hoxsey's remedies puts a real obstacle in the way of further harmful exploitation.

More activity in the same direction would be very desirable.

A P C VIRUS

The announcement some months ago of a successful clinical trial of a vaccine reasonably effective against infection with Type 3 APC virus gives encouragement to the hope of progress in a field in which the pursued is still far ahead of the pursuer. "APC" means "adenoidal, pharyngeal, conjunctival". It seems a pity to make confusion by using a designation which has been attached so firmly to a widely used relief for symptoms that it will be transferred only with great difficulty to the cause. APC will mean a capsule, not a virus family, for most of us for many years to come.

The South Carolina Surgical Society elected new officers during its eighth annual meeting in March.

Dr. Edward F. Parker of Charleston is new president; Dr. Claud W. Perry of Anderson, vice president; and Dr. J. Robert Thomason of Greenville, secretary-treasurer.

Dr. Alton G. Brown of Rock Hill on March 23 made the presentation of a portrait of Dr. Frederick E. Kredel to the Medical College of South Carolina.

The presentation was made on behalf of surgery residents trained under Dr. Kredel, the institution's first full-time professor of surgery. Dr. Kenneth M. Lynch accepted the portrait, which was executed by Lee Settlemeyer of Rock Hill.

The schedule included scientific sessions, with Dr. H. R. Pratt-Thomas, professor of pathology at the college; Dr. Robert P. Walton, professor of pharmacology and D. Melvin H. Knisley, professor of anatomy participating.

WOMAN'S AUXILIARY
SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. E. Gordon Able, Newberry, S. C. **Publicity Secretary: Mrs. Ritchie Belser, Charleston, S. C.**

MRS. E. GORDON ABLE
President

Mrs. E. Gordon Able of Newberry was born into a professional family. Her father, Dr. Charleigh T. Dowling was a dentist and her grandfather was a dental surgeon in the Confederate forces. Her mother was the former Selina Moss. A native of Norway, in Orangeburg county, her early years were spent at "The Sycamores," a lovely old home built by her maternal great-grandfather, with much of her growing-up done at the Dowling summer place in Bluffton.

The former Elizabeth Dowling attended Chicora Academy to prepare for entrance to Converse College and from this college, three years later, she received her B. S. degree in Sociology and History. While in college, she was active in campus life, participating in college sports, the Dramatic Club, Y.W.C.A., and the Carlisle Literary Society. During her senior year she was house president of Cudd Building. Later she worked toward a degree in Library Science at the University of North Carolina.

In 1933 she married Dr. Edward Gordon Able, son of a physician, and a well-known general surgeon of Newberry.

She has been active in the Newberry Civic League, and she has been a member of the executive board of this 200-member organization for 20 years. As a Leaguer, she was appointed to the Board of Control of Margaret Hunter Park and Pool, where she supervised beautification and recreation programs. She was chairman of the committee which restored, renovated, and decorated the Newberry County Community Hall and still serves in this capacity and also as chairman of the House and Grounds Committee of the Hall Commission. She is Vice President of the League, serves as a nurses' aid with the Red Cross Bloodmobile, is a member of the Newberry Garden Club, and a member of the St. Luke's Episcopal Church.

Mrs. Able's past activities, aside from her work in the medical auxiliary, include a term as President of the Newberry Woman's Club, Red Cross Surgical Dressing chairman of Newberry County during the war, a member of the committee which planned Newberry county's gigantic 1939 Sesquicentennial Celebration.

Her special interest in the Auxiliary began with the reorganization of the Newberry Auxiliary on a local level at Mrs. Able's own home. With her qualities of leadership so evident in every undertaking, she was a natural choice for President of the group at that time. At the county level, she was a charter member of the Third District Auxiliary and has served terms as vice-president and president of this District. On a state level she has served as a member of the nominating committee, four terms as membership chairman, and as first vice president.

DANIEL LESESNE SMITH

PRESIDENT ELECT

Born 1905 at Newry in Oconee County.

Graduated from The Citadel 1927.

Graduated from Medical College of South Carolina 1931.

Interned at Duval Medical Center in Jacksonville.

Took pediatric training at University of Cincinnati.

Episcopalian. Former vestryman.

Civic affairs: former president of Jaycees; Polio Foundation; Boy Scouts.

Medical affairs: secretary, treasurer and twice president of Spartanburg County Medical Society.

President of S. C. Pediatric Society.

President of Alumni Association of the Medical College of S. C.

Member of "Committee of 17" which obtained first appropriation for the new Medical College hospital.

Councillor of S. C. Medical Association for 8 years.

On faculty of Southern Pediatric Seminar for 20 years; registrar and program chairman for 8 years.

Married to Clara Ravenel in 1936; have four children.

Was major in Medical Corps, served 4 years—two years in Pacific theater.

ANNOUNCEMENTS

The Journal is very glad to have announcements and news of meetings and other events of medical interest. The Journal is mailed about the 10th day of each month. In order to have items appear in any given issue, they should be in the hands of the editor by the 15th day of the preceding month.

MOUNTAINTOP MEDICAL ASSEMBLY
WAYNESVILLE, N. C.

JUNE 21-22-23

6 OUTSTANDING SPEAKERS

Dr. William Hamm, Atlanta, Ga., Plastic Surgery

Dr. Park Nicely, Knoxville, Tenn., Urology

Dr. Julian Price, Florence, S. C., Pediatrics

Dr. Robert Greenblatt, Augusta, Ga., Endocrinology

Dr. Kinloch Nelson, Richmond, Va., Internal Medicine

Dr. Phillip H. Jones, New Orleans, La., Internal Medicine

15 HOURS APPROVED STUDY A A G P

WRITE: J. F. HAMMETT,M. D.
P. O. Box 669, Waynesville, N. C.

DUKE MEDICAL POST GRADUATE COURSE
DUKE UNIVERSITY
DURHAM, N. C.

JUNE 18, 19, 20, 21, 1956

1. All meetings will originate in Room 2031, Duke Hospital.
2. Registration. Duke Hospital. Room 2031. Registration Fee $25.00.
3. Rooms available in the University Graduate Dormitories.
4. Meals may be obtained in the Graduate Dormitory or in the Oak Room in the University Union.
5. All participants of the course will be guests of the faculty of the Medical School at an informal dinner on the evening of June 20.
6. Ward Rounds or a Visit to the Clinics are available on each afternoon. More interesting rounds can be prepared if the participants will indicate their preference in advance.
7. Certificates of Attendance will be provided.
8. Twenty-eight hours of formal instruction is offered during the four day period.

Director of Post-Graduate Education, Box 3088
Duke Hospital, Durham, North Carolina

NEWS

Dr. D. H. Williams has opened his office for the general practice of medicine in the Weinberg Building in Manning.

Dr. Williams, 34, was born at Johnston, S. C. He received his education at Newberry College, the Medical College of South Carolina, and completed his internship at Columbia hospital. During World War II he served overseas as chief pharmacist mate.

Dr. Kenneth W. Krueger of Hartsville was made an associate member of the American College of Physicians during its 37th Annual Session at Los Angeles, California in April.

The Greenville County Medical Society met on May 1 at the Elks Club. Dr. William Hutson Prioleau, clinical professor of surgery at the Medical College of South Carolina was the speaker.

The Greenville County Medical Society has announced the affiliation of Dr. Walton W. Hamilton with Drs. Will S. Judy, Willis S. Hood and T. E. Whitaker in the practice of radiology. Their offices are at 107 E. North St., Greenville.

Dr. Bill R. Ewing, formerly of Greenville and Simpsonville, is now associated with Drs. Smith and Ligon in the practice of medicine and treatment of patients at Williamston Hospital.

Dr. Ewing is presently completing special study in the field of anesthesiology and is in Williamston only part of the week. With his background of special study, Dr. Ewing is expected to complete the staff of the hospital.

On April 20 five sections of the South Carolina Public Health association elected new officers at the 33rd annual meeting of the association in Charleston.

Dr. J. N. Holtzclaw of Greenville is the new chairman of the medical section. Dr. Malcolm Dantzler of Marion will serve as secretary.

Dr. Albert P. Thomas and Dr. James C. Steele opened their offices on Monday, April 16, for the practice of medicine in Lexington.

Dr. William W. Goodlett has opened his office for the general practice of medicine at 311 E. Coffee St., Greenville.

Dr. Sydney Garrett, native of Six Mile, is now associated with Cannon Memorial Hospital in the general practice of medicine.

Dr. Garrett is a graduate of Berea College, Berea, Ky., and the Medical College at Charleston. He is a member of Phi Rho Sigma Medical Fraternity and served his internship at Columbia Hospital in Richland County.

THE KERSHAW COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Kershaw County Medical Society was held on May 9, 1956, at Emerson's Restaurant. Dr. Viola Nelken, was hostess to the society for the May meeting.

After dinner was served, Dr. Grayson Shaw, president, was in charge of the meeting. The regular order of business was discussed, which included a resolution made by the society requesting compulsory diphtheria immunizations before entrance to school. Dr. Zemp, delegate, reported this was to be introduced at the 1956 meeting of the South Carolina Medical Society.

Dr. Nelken introduced her guest for the evening, Mr. F. B. Johnson, of the Wyeth Company, who showed an interesting film on "Sparine", a tranquilizing drug. There was a brief question and answer period, after which the society adjourned.

Viola D. Nelken, M. D.
Secretary-Treasurer

MINUTES

State Board of Health Executive Committee

January 18, 1956

(Excerpts)

It was moved by Dr. Barron, seconded by Dr. Platt, that the State Health Officer postpone further action in connection with the Marlboro Nursing Home licensure in view of developments reported to Mr. Ulmer in letters from the proprietor and the Palmetto Life Insurance Company. Passed.

It was moved by Dr. Hanckel, seconded by Miss Chamberlin, that approval be given on the acceptance of Dr. Eleanor Townsend in the position as clinical pathologist for the Board of Health. Passed.

A letter of appreciation from Miss Ellie C. Nelson was read and received as information.

It was moved by Dr. Barron, seconded by Dr. Smith, that the Board of Health underwrite the operation of the Spartanburg County mobile fluoroscopic unit to the amount of $3,000 until July 1, 1956. Passed.

It was moved by Miss Chamberlin, seconded by Dr. Hanckel, that the Committee approve in principle the proposal that the State Board of Health shall, when funds become available, employ a nurse education director and a secretary for the purpose of assisting the University of South Carolina, the Medical College of South Carolina, other State institutions, and the Charleston County Health Department in developing a nationally accredited public health nursing education program. Passed.

CORRESPONDENCE

The National Foundation For Infantile Paralysis
New York 5, N. Y.

April 23, 1956

Dr. O. B. Mayer, President
South Carolina Medical Association
Dear Doctor Mayer:

May I take this opportunity, on the occasion of the annual meeting of the South Carolina Medical Association to express thanks from the National Foundation for Infantile Paralysis to the society as a whole and to its individual members for their excellent cooperation with the state health department and the National Foundation in the successful conduct of the poliomyelitis vaccine demonstration program in South Carolina during 1955.

The chief beneficiaries of this program, of course, were the South Carolina school children, mainly in the first and second grades, who received one or more injections of vaccine supplied by the National Foundation during the year 1955. A total of 243,981 cc. of vaccine was supplied.

You may be interested to know that, thanks to your help, 118,075 South Carolina children received at least one inoculation; 87,780 received two inoculations; and 2,365 received a third (booster) inoculation with this vaccine up to October 29, 1955.

Approximately 46% of the South Carolina children in the 5-9 age group, the age group most susceptible to paralytic poliomyelitis, thus obtained a high degree of protection against the disease in 1955 as a result of this program.

The cooperation of the South Carolina Medical Association helped materially to account for this fine record.

While this is a formal expression of gratitude for your help, the real expression must come from the parents of those many children in South Carolina who feel free from the threat of paralytic poliomyelitis in their families now that the 1956 poliomyelitis season is at hand.

Very cordially yours,
Hart E. Van Riper, M. D.
Medical Director

DEATHS

DR. J. L. SHEPPARD

Dr. J. L. Sheppard, 46, of Jefferson died suddenly in April after a period of declining health.

Doctor Sheppard was a native of Laurel, Ohio, and was a practicing physician in Jefferson for the past four years. He was a Methodist and a member of the Masonic order and the Chesterfield County Medical Association.

DR. EDWARD WITHERSPOON BARRON

Dr. Edward Witherspoon Barron, 79, of Manning, died March 14th at the Clarendon Memorial Hospital following an illness of one week.

Dr. Barron was born in Manning February 13, 1877. He was educated in the Manning schools and graduated from the Medical College at Charleston.

He practiced medicine in Salley for two years, then in Manning where he followed his profession until he entered the service in World War I.

After his discharge from the service, Dr. Barron went to Boston and specialized in pediatrics. Upon completion of this training, he went to Columbia where he practiced until his retirement 11 years ago.

DR. WADE STACKHOUSE

Dr. Wade Stackhouse, 88, one of Dillon County's oldest and most prominent citizens, died March 17 at his residence after several years of limited activity and declining health.

He was born in Marlboro County on October 28, 1867. There he spent his early years and graduated from high school. After winning a scholarship to Peabody College he was graduated in 1887 and went from there to Vanderbilt University where he garduated with top honors—winning all of the medals in his class in 1892. Two years later he took a course at Polyclinic Hospital in New York City and returned to the Minturn Community of Dillon County where he practiced medicine for 13 years.

In 1904 he moved to Dillon where he maintained his practice. Gradually he began to acquire various tracts of land, became more and more interested in scientific farming. He took an active part in the effort to found Dillon County and in 1908 was elected to the state Senate from Marion County. For a number of years he served as chairman of the County Board of Commissioners and helped greatly in the progress of the new county. During these days he gave up his practice of medicine. One of his most outstanding accomplishments was the successful promotion of the coastal highway—the first all-paved road across the State of South Carolina. This highway was eventually to become U. S. Highway 301. In 1918 he organized and built the Carolina Milling Company, which became one of the largest flour and feed mills in the Southeast.

Dr. Stackhouse became a pioneer in the idea of raising cattle in this section and played a great part in the growth of scientific farming in the South.

BLUE CROSS . . . BLUE SHIELD

BLUE CROSS — BLUE SHIELD

The material for this article was either suggested by or was actually abstracted from editorials and news releases bearing on the proposal of Michigan's Blue Cross to materially increase rates.

In an editorial, *The Detroit Free Press*, on February 27, discussed the causes of skyrocketing of hospital charges which are reflected in Blue Cross rates. It said: "The public's demand in the last decade for better medical and hospital care has been great. Therefore, on top of inflation must be added the cost of this improved care."

It then examines the question: "Do the allegedly excessive rates (of Blue Cross) reflect only inflation and improved care?" Surveys of hospital cases covered by hospital insurance seems to prove that such is not the case. Such studies clearly indicate that abuses have occurred. These abuses take the form of unnecessary hospitalization, prolonged stays for convenience or comfort, and excessive use of drugs and laboratory facilities. However, it is the opinion of the editor that, even though glaring instances have been found, this type of overutilization does not occur sufficiently often to make a great difference in hospital costs. Our thinking in South Carolina is somewhat similar, but with one great difference—a difference which does affect our rates adversely. It is our experience that we have far too many instances of hospital admissions primarily for x-ray examination and other ancillary services. These cases are actually diagnostic admissions, but they are covered too often by a thin veneer which hides their true character—an admission diagnosis, and a statement that they were admitted for diagnosis *and* treatment. In too many instances, the admitting diagnosis is trivial, and the diagnostic x-ray examinations could have been done on an outpatient basis with equal accuracy but with increased cost and inconvenience to the patient.

The *Free Press* then asks whose fault it is that abuses have occurred: "Is it hospitals for operating inefficiently? Is it physicians who find it convenient to group patients in hospitals for quick and lucrative rounds of call? Is it patients who unnecessarily demand and get from their doctors a bed and costly care? Is it Blue Cross for permitting such known abuses to occur?" He suspects the answer to each question is, "yes."

In Michigan, a bill was introduced in the legislature to require Blue Cross to add a deductible clause to every contract it offered. The bill had the blessings of the insurance commissioner. Actually, Michigan has offered for about a year a contract with a deductible clause. It has not proved popular. We in South Carolina, through acute emergent necessity, made the cost of room and board in ward accommodations a deductible item in all admissions. It was done in lieu of an increase in rates across the board. Its greatest cost to a hospitalized member was $18.00 per hospital admission. In some hospitals it was as low as $12.00. However, it has not proved to be generally popular, and we have lost some groups and some non-group members because of it. Although the inclusion of the deductible provision in the contract did prevent an over-all increase in membership rates, it did not reduce hospital costs nearly as much as had been expected. Although a deductible feature may be continued for a time, it is no panacea for reducing hospital costs.

The unions in Michigan have entered actively into the discussion of Blue Cross problems. They want a contract with more benefits at lower cost. However, as the editor of the *Free Press* so wisely asserts, "You can't slap economics in the face. You can't legislate Utopia." He thinks, as do 3,600,000 people in Michigan, that Blue Cross is doing a good job, and that in Michigan, as elsewhere, Blue Cross is "merely a victim of our rising economy just as everybody else is."

However, he believes that physicians, through their dealings with patients and because they control both hospital services and Blue Cross policies, have failed to take an active public stand on the abuses under the voluntary hospitalization insurance plans. He states: "Because they are so closely involved in the abuses and because voluntary plans were their answer when socialized medicine appeared around the corner, they should be available to counsel the public."

In a recent news release, President Walter P. Reuther of UAW made some thought-arousing statements. He opposed a co-insurance deductible contract on the grounds that such a contract would represent an unnecessary reduction in protection which neither labor nor industry wants. He believes that mandatory co-insurance and deductible provisions would handicap Blue Cross in its competition with other carriers. He strongly opposes governmental intervention in voluntary health insurance plans, beyond enabling legislation and rate regulation.

Reuther thinks the way to eliminate waste and excessive hospital costs is to attack the problem directly at the hospital and doctor level. He thinks that co-insurance and deductible provisions are fundamentally wrong because health protection is not like automobile insurance. There is not a similar op-

portunity to exercise voluntary delay. When a person goes to the hospital, there is usually a sufficiently serious problem present which demands early action. Quoting him: "People cannot go to a hospital unnecessarily without having a doctor admit them. When people stay in hospital too long, or receive the wrong kind of services, a doctor is usually responsible."

His last paragraph is significant for he speaks, or claims to speak, for labor. He says:

"Several hundred influential insurance companies are standing by to dismember Blue Cross, hoping to pick up the pieces. If Blue Cross should fail, labor will not be satisfied with the inferior offerings of commercial insurance. As the Director of the Cincinnati Blue Cross Plan wrote in a recent article in the Journal of American Hospital Association, 'If voluntary prepayment does not provide adequate and continuous protection, it will be discarded in favor of an involuntary, tax-supported program.'"

The remarks of Mr. Reuther are those of a layman, but one who studies health insurance. He and other labor leaders are constantly seeking greater benefit; for less cost. His ideas and beliefs are worthy of consideration by Blue Cross, doctors, and hospitals. In one sense, his thinking is always biased in favor of the union. However, when he attempts to *show* Blue Cross how to give rather than simply to demand what he desires, he should be listened to.

We in the South Carolina Blue Cross office do not place the onus for high hospital costs on the doctor to nearly the same degree as does Reuther. We believe that most doctors and most patients are honest. We know that most members of Blue Cross demand all they are entitled to under their contracts. That is a natural demand. It is our feeling that in most instances abuses, if they may be so called, arise from a failure to understand what the contract provides and what it excludes. This lack of information applies equally to the patient and to the doctor. Demand for uncovered benefits usually arises from a lack of knowledge of or a misinterpretation of the terms of the agreement. To a minor degree they arise from carelessness.

Perhaps, the matter of diagnostic hospital admissions is the most difficult to understand and to explain, and benefits under the provisions of the contract are the most frequently abused. The crux of the policy is: Hospital admission and benefits are provided only to members who actually are sick, and sick enough to require hospital treatment. They are not provided for x-ray studies or other laboratory procedures that could be done equally well on an outpatient basis, and to people who are not sick enough to require hospital care. When such x-ray benefits are provided to inpatients, they are limited to those procedures which have a direct bearing on the illness being treated. Incidental, concurrent examinations, without direct relationship to the illness at hand are excluded.

The next most difficult exclusion to understand is that concerning waiting periods, especially waiting periods for conditions which were present on the effective date of the contract. Denial of benefits in connection with the treatment of pre-existing conditions does not require prior knowledge of the condition by the patient or the doctor. It does not require that symptoms must have been present at the time the contract was made. It is necessary only that it be presumed that the condition was present on that date. If so, the member is not eligible for treatment of the condition under his Blue Cross contract until expiration of a waiting period of one year.

J. Decherd Guess, M. D.
Medical Director

BOOK REVIEWS

PATHOLOGIC PHYSIOLOGY: MECHANISMS OF DISEASE. Second Edition. Edited by William A. Sodeman, M. D., F.A.C.P., Professor of Medicine, School of Medicine, University of Missouri. 963 pages. W. B. Saunders Co. 1956. Price $13.00.

This is the second edition of a cooperative undertaking by 29 authors presenting the abnormal physiology of disease. The subject matter is divided into systems such as respiratory, circulatory, infections and allergy, etc., and further subdivided into discussions of specific topics. These are concisely and lucidly presented with good illustrations. In view of the tremendous field which it attempts to cover the result is of necessity brief and covers only the more important aspects. However, at the completion of each chapter there is an adequate bibliography for those interested in more detailed studies.

Despite the title much of the book is taken up with normal physiology which is followed by good explanations of various function studies used in clinical medicine. Only then is the abnormal physiology of different disease states discussed as it pertains to the preceding. This results in a good review of the pathogenesis of symptoms and signs which is incorporated in a short summary of specific illnesses.

This book serves its primary purpose in being more clinical than the usual texts such as Best and Taylor's "Physiological Basis of Medical Practice" and limiting its subject matter to practical aspects for the student. Consequently it has its greatest value as a supplementary student text and cannot be recommended as a reference work.

Charlton deSaussure, M. D.

PEPTIC ULCER—DIAGNOSIS AND TREATMENT. Clifford J. Barborka, M. D. and E. Clinton Texter, Jr., M. D. Little, Brown and Company, Boston, 1955. Price $7.00.

This little book presents a rather concise summary

of presently acceptable methods of diagnosis and treatment of peptic ulcer. The viewpoint given is primarily that of an internist and the section concerned with surgical therapy is rather sketchy, not only with regard to technique, but with regard to indications for operation. However, there is an excellent discussion of the postgastrectomy syndromes and their management. The detailed presentation of diets, menus, etc., should be of great value to the student and practicing physician. The attitude of the authors toward gastric ulcer is a rather conservative one. Their evaluation of the results of various operations seemed adequate.

Henry W. Mayo, Jr., M. D.

CANCER CELLS. By E. V. Cowdry, Director, Wernse Cancer Research Laboratory, Washington University, St. Louis. 677 pages, 137 figures. Philadelphia: W. B. Saunders Co., 1955. Price $16.00.

This book deals with the most perplexing and probably the most important cell that has ever been discovered. Certainly insofar as abnormal cells are concerned the neoplastic one is supreme. The fact that some 570 pages text and 2100 references are committed to this subject emphasizes the complexity and vast implication of the subject. Dr. Cowdry emphasized the far-flung nature of the problem when he commented in the preface: "No individual will ever be able to present adequately what is known about cancer cells. His background and training are sure to be deficient in respects too numerous to mention." This may be true, but Dr. Cowdry has done a remarkable job of culling, condensing and assembling the observations and facts about this biologic pirate.

The first five chapters are devoted to histologic, pathologic, and physiologic fundamentals of cell behavior, but this reviewer hastens to add that the succeeding chapters are of much greater general interest and such items as endoplasmic reticulum should not frighten the general reader into a disorderly retreat. The chapter dealing with the 400-odd known carcinogens in which such entitities as Thorotrast, cigarette smoke, food, estrogens and chronic irritation are dealt with liberally is a fascinating and stimulating part. Viruses, heredity, cellular mutation, trauma, and spontaneous regression are all covered in their relationships to neoplastic disease.

In relation to the field of research and cancer control which Dr. Cowdry also discusses it is sobering to be reminded that two discoveries concerning cancer in 1913 and 1923 each of which earned the investigator the Nobel prize did not yield any permanent or improved results in cancer control. The chief advance has actually been in the field of early diagnosis and our better comprehension of the time it takes many cancers to develop. Once fully developed it is still difficult to alter the roll of the dice.

It appears that virtually any facet of the cancer cell may be found reflected in the pages of this book.

H. R. Pratt-Thomas

COLLECTED PAPERS OF THE MAYO CLINIC, Edited by R. W. Hewitt, et al 1955. W. B. Saunders Company, Philadelphia. Price $12.50.

This forty-sixth volume of a series is, as stated, oriented to the interests of the general practitioner, the general surgeon and the diagnostician. A number of the papers are reprinted in full and many others in abridged or abstract form. It reflects in adequate measure the current observations and opinions of the Staff of the Mayo Clinic in various fields. It includes a cogent article on the ethics of medical writing or how "to be in truth an author". The book is well-illustrated and has an adequate index. Any doctor will find material of interest to him in various parts of this comprehensive volume of 843 pages.

Fred Kredel, M. D.

CHRISTOPHER'S TEXTBOOK OF SURGERY—SIXTH EDITION. Edited by Loyal Davis 1956, W. B. Saunders Company. $15.50.

Much progress has been made in many fields of surgery since the Fifth Edition of this well-known text in 1949. The new editor has assembled an imposing array of collaborators to write the sections for which they are particularly competent. Yet the volume is so well organized that there is remarkably little overlap of material and reflects the great skill Dr. Davis has exemplified in his many years as editor of surgical journals.

An interesting innovation at the beginning of each chapter is a brief biographical sketch of the particular author. The reader may thus acquire a certain sense of personal acquaintance with the writer of each section. Articles on the history of surgery by Allen Whipple and on the training of a surgeon by Paul Hawley are inspiring to the student who may consider a career in surgery.

All the sections are completely up-to-date and contain references to the current literature. This edition will prove of value not only to fourth year students but also to residents and practicing surgeons. It is a comprehensive volume of 1484 pages covering the broad field of modern surgery.

Fred Kredel, M. D.

EXPERIMENTAL TUBERCULOSIS: BACILLUS AND HOST with Addendum on Experimental Leprosy. Ciba Foundation Symposium Edited by G. E. W. Wolstenholme, O.B.E., M.A., B.Ch., and Margaret P. Cameron, M.A., A.B.L.S., Assisted by Cecilia M. O'Connor, B. Sc. 396 Pages with 69 Illustrations, Cloth Bound $9.00. Little, Brown and Company, Boston 6, 1955.

The Ciba Foundation, an educational and scientific charity, founded by a trust deed in 1947, and supported financially by the world-wide chemical and

pharmaceutical firm with headquarters in Switzerland, provides an opportunity for research workers in medical and scientific fields in all countries to get together informally and exchange information and ideas. This book comprises not only the formal papers of such a symposium on the stated subjects, but also the informal discussions by the participants which, as stated in the preface, attempt—"to give the reader a sense of participation in an informal and friendly occasion". Much stimulating and interesting information is brought together in this book which would not be readily available elsewhere. Although it lacks any immediate useful information for the clinician in the field of tuberculosis, it deals with the intricate chemical structure of the tubercle bacillus, tissue reactions to bacilli and their products, hypersensitivity and desensitization and biochemical and cellular factors influencing the fate of tubercle bacilli in tissues. Some light is shed on the complicated biochemical reactions involved in the well-known clinical phenomena such as the adverse effect of the steroid hormones on tuberculous infection and the known enhancement of tuberculosis by diabetes. This and much more valuable information contained in this book is most stimulating and should prove most valuable to the research worker and investigator. It certainly highlights our limitation of knowledge and points out sources of investigation from which our future progress in the field of tuberculosis must come. The Addendum on leprosy points out a most interesting cross-immunization feature of these diseases and indicates a definite need for correlation in some of the fields of research.

D. B. Gregg, M. D.

DISEASES OF THE CHEST, by H. Corwin Hinshaw, M. D., Ph. D., and L. Henry Garland, M. B., B. Ch. W. B. Saunders Co., Phila. 1956. Price $15.00.

This new book on diseases of the chest unquestionably will fill an exceedingly important place in the library of physicians, surgeons and medical students. It represents, primarily, the vast experience of the authors and their colleagues in the diagnosis and treatment of diseases of the bronchi, lungs, pleura and mediastinum. It does not consider diseases of the cardiovascular system and it does not consider some diseases of the mediastinum such as carcinoma of the esophagus. As one would expect, from a knowledge of the authors' primary interest, the emphasis is on infectious diseases of the lungs, and particularly tuberculosis and diseases with which it might be confused. The format and illustrations are splendid. The index and the bibliography are more than adequate. The book is to be recommended highly as a text for medical students and postgraduate students, and as a reference book for physicians and surgeons.

Edward F. Parker, M. D.

CLINICAL RECOGNITION AND MANAGEMENT OF DISTURBANCES OF FLUID BALANCE. By John H. Bland, M. D. 500 Pages Illustrated. Philadelphia, Pa.: W. B. Saunders Co., 1956.

The second edition of this book, appearing 4 years after the first, has been improved in format and enlarged in content. Instead of the paper-backed, notebook-sized first edition, it is now cloth bound and in book form. Chapters have been added on hydrogen ion control, water and electrolyte deviations in liver diseases, pulmonary diseases, central nervous system diseases and trauma. The section on the hormones and disturbances of the adrenal cortex has been greatly increased, in keeping with the rapid advances in knowledge concerning the gland. The important advances in surgical metabolism are incorporated in this issue and the work of Francis Moore in this field is given particular, deserved emphasis. The author again takes pains to present in general the subject for clinical use at the bedside, designed especially for medical students and busy practitioners. In view of such designation, one may overlook the criticism that insufficient data are presented to support the concepts recorded in the text. The material is quite complex and becoming more so. The success with which the author simplifies the subject accounts for the book's reputation as an excellent aid in the clinical handling of problems of fluid and electrolytes.

Louie B. Jenkins, M. D.

Books in the Physician's Life by F. Marti-Ibanez in *Internat. Record of Med. & G. P. Clinics*, Oct. 1955.

Many of the obstacles that stand in the way of the progress of modern Psychiatry derive from its grotesque terminology, a vast multiform jargon unnecessarily confusing, and from the compulsion felt by many colleagues to express themselves obscurely and technically so that, since only a few will understand them, they will be subject to a minimum amount of criticism. "Not only don't I understand the mysterious dialect of psychiatrists," said Maranon, "but when I hear them speak, I comprehend but half of what they say." This is the more deplorable since the "verbal" style of Freud himself—and before him Charcot's dialectic and Kraepelin's didactic styles—set one of the finest examples of clarity and harmony. Their prose was beautiful because of its pellucid *simplicity*.

SCISSORISMS

THE DOCTOR'S DREAM

I had a dream, and in that dream
I thought that I had passed
Into that realm of blissful rest
That doctors reach at last.

I dreamed of all the ups and downs
Of thirty years of practice,
That brought with many a scented rose,
Its compensating cactus.

. . . About the doctors and their bills,
The good and bad we did,
The lives our skill so often saved,
Mistakes the earth had hid.

The strictures on our moral worth,
The sins we do commit,
And universal dump we get,
By wholesale in the pit.

For many hold 'twould be so hard
Through Heaven's gate to wheedle
A doctor as to drive a camel through
A hypodermic needle.

Yet in my dream there seemed to be
Misapprehension here;
For I felt sure physicians will
Among the saints appear.

. . . For from the fount from whence they're cleansed,
E'en doctors may come clean;
God gives to no exclusive class
The power to enter in.

. . . And thus I dreamt that round me stood
The victims of disease,
The patients I had failed to cure,
Though some had paid my fees.

One said, "It is a happy place,
My bliss is unalloyed;
Through your mistakes just ten years more
Of Heaven I have enjoyed."

. . . Another made this queer complaint;
"I'm prematurely sent;
The bungling doctors got me here
Before development.

"I'm filled with love, my joy overflows,
But what I most regret,
On earth I should have staid and got
Capacity for it."

I here got shaky in my shoes,
And asked if they'd attack us,
And raise a rumpus in these courts,
With questions of malpractice.

"Oh, no!" he said, "there's no redress,
No righting this affliction:
For courts are not in session here
For want of jurisdiction.

"And if they were, in our behalf
We must ourselves appear;
A first-class lawyer can't be had,
I never found one here" . . . . .

William Snowden Battles, M. D.

BIOGRAPHICAL SKETCH
ISAAC A. ABT
(Dec. 18, 1867 — Nov. 22, 1955)

Recently there died in Chicago one of America's greatest men. He was eighty-seven years old and had been granted sufficient time and the opportunity to accomplish much for mankind. He was not a general nor was he a statesman, though he had planned many important campaigns and when and where diplomacy was necessary he had used his gentle, calm, convincing way to get results. This man was only a doctor—a specialist in the diseases of children. Dr. Isaac A. Abt was one of our earliest and in his time, one of the best trained "Baby Doctors" in the United States. In his early years he had good training at home and then several years abroad perfecting himself.

Most of his life was spent in Chicago where he gave many hours to his practice and teaching. His clinics and his professorship were begun in 1897.

Early he was the President of the American Pediatric Society and a founder of the American Academy of Pediatrics and its first president in 1930.

He contributed hundreds of articles to pediatric literature and wrote several books.

His autobiography called *The Baby Doctor*, which was published in 1944, is full of interesting anecdotes and shows the advances made in the diagnosis and treatment of diseases of children during his life time.

For a great many years he was the editor of *The Year Book of Pediatrics*. He is credited with being the first to give diphtheria antitoxin and to use an incubator in Chicago. He planned and built the first Children's Hospital in that city.

Dr. Abt was a member of many state and national societies and of a number of others abroad.

In addition to being an excellent doctor and an unusually gifted teacher, he had a lovable disposition and a delightful sense of humor, which endeared him to his hundreds of friends far and wide in the United States and elsewhere.

He, like a meteor, illumined the world and now has passed on. But even so, the good that he did lives on in the bodies, the minds and the hearts of his patients, his pupils and in Pediatrics.

R. M. P.